STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145949	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Home	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)
F 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33970 Based on observation, interview and record review the facility quarantined 6 residents to remain in their rooms (R1, R21, R36, R43, R53 and R59) on 5/28/24 without any clear reasoning. This failure caused R53 to be very upset and anxious regarding his inability to leave his room. Findings Include: The Facility's Policy for Outbreak Investigation dated 4/1/2024 documents, It is the policy of (This Facility) that outbreak measures will be instituted whenever there is an incidence of infections above what would normally be expected, considering seasonal variations. The Infections Preventionist will conduct the outbreak investigation. The Facility's Your Rights and Protections as a Nursing Home Resident pamphlet dated 8/2021 documents, You have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose You have the right to decide when you go to bed, rise in the morning, and eat your meals. Upon entry to the facility on [DATE] at 8:45AM no staff members were wearing masks and V20 (Receptionist) stated there were no known outbreaks or illnesses happening in the building at that time. At this time, R53 was in the main dining room eating breakfast with three other male residents. R53 appeared to be friendly and talkative with these men. R53's Admission Activity assessment dated [DATE] documents, R53 prefers to be with people and enjoys large groups and small groups. On 5/28/24 at 9:00AM multiple staff members were observed passing out surgical masks to other staff members instructing them that we are in outbreak status we need to mask. On 5/28/24 at 11:00 AM V3 (Registered Nurse/Assistant Director of Nurses/Infection Preventionist) stated, I decided we have had some upper respiratory infections lately, so I am having the staff mask to be careful. V3 did not indicate at that time that residents were being asked to remain in their rooms. (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 0550 Level of Harm - Actual harm Residents Affected - Few	On 5/28/24 at 3:15 PM V6 (Licensed Practical Nurse) stated, This is ridiculous. We have had allergic rhinitis in this building for the past couple of weeks because it is that time of year. Nothing has changed other than (Survey Agency) coming in for an inspection. V6 stated, (R53) is very mad about having to stay in his room. On 5/28/24 at 3:30 PM R53 stated, What the hell is this all about? I have been hacking and coughing for at least a week and now that I am starting to feel better. I have to stay in my room? I am almost [AGE] years old, if I die, I die. I would rather eat in the dining room than be made to sit in my room looking at the wall while I am eating. If I am so contagious, why is he (R62/roommate) still alive and able to leave the room? This is infuriating that no one here knows what the hell they are doing. Pure chaos. On 5/29/24 at 8:30 AM V5 (Licensed Practical Nurse) stated, (R53) is very irritated with staying in his room. V5 confirmed, (R53) had been hacking for the past week or so. V5 stated, Everyone has had that allergy cough going on. (R53) actually sounds better than he has. (R1) is one of them that we were instructed to keep in her room, and she sounds no different than she ever has. I just don't understand the reasoning on any of these. On 5/29/24 at 9:15 AM R53 was sitting inside of his room speaking with V7 (Social Services Director) saying, When am I getting out of here? I need to shower. I want to go to the dining room. If the risk is mine, I will take it, if it is because I am infectious, I think we may have killed (R62/Roommate). On 5/29/24 at 9:20 AM V7 (Social Services Director) confirmed R53 had been upset and wanting information regarding when he could leave his room. V7 confirmed that both R53 and his roommate R62 are up and about their room independently and neither of them was wearing masks inside of the room. V7 confirmed R62 was free to come and go from the room as he wished and that she didn't know when R53 would be able to leave his room. That is up to (V3 RN/ADON/IP). On 5/30/24 at 10:30 AM V3 (Registered Nurse/Assistant Director of Nurses/Infection Preventionist) stated she implemented masking because there had been an uptick of respiratory issues at the facility over the weekend. V3 confirmed she instructed staff members to keep R1, R21, R36, R43, R53 and R59 in their rooms related to upper respiratory symptoms. V3 confirmed she did this prior to completing any investigation into duration of symptoms, fever status or speaking with floor staff regarding status of the residents who were being asked to stay in their rooms. V3 stated, I found out (R53) was upset, I just didn't have time to investigate it right then. V3 confirmed that after her investigation into R53's respiratory status he could have come out of his room with a mask on himself and did not need to be kept in his room. V3 confirmed R53 was encouraged to stay in his room on 5/28/24 for lunch and supper meals and on 5/29/24 for the breakfast meal unnecessarily. V3. Stated, I over reacted and I owe (R53) an apology because he was so upset.

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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. 31283 Based on interview, observation and record review, the facility failed to ensure fall interventions were implemented to prevent further falls for one of four residents (R38) reviewed for falls in the sample of 29. Findings include: The facility's Fall Reduction Program policy (revised 09/01/21) documents the following: All residents will receive adequate supervision, assistance and assistive devices to aid in the prevention of falls. Each resident will be evaluated for safety risks including falls and accidents. Care Plans will be created and implemented based on the individual's risk factors to aid in the prevention of falls. On 05/28/24 at 10:10 AM, R38 was lying in a low bed with a fall mat in place next to her bed. R38 was nonverbal and did not respond to verbal stimuli when approached due to her impaired cognition. R38's Fall Investigation (dated 01/08/24) documents the following: Nurse notified at this time of resident (R38) sliding out of chair in dining room. CNA (Certified Nursing Assistant) stated resident slid out of chair and did not hit head. R38's current care plan documents the following focus: Risk for falls characterized by history of falls/injury, multiple risk factors related to: impaired balance, poor coordination, poor safety awareness. This same care plan documents the following fall prevention intervention: 01/08/24: Re-educated staff to ensure (R38) has (non-slip mat) placed under her. On 05/30/24 at 02:00 PM, V17 (Licensed Practical Nurse/Care Plan Coordinator) stated that after investigation of R38's 01/08/24 fall, R38 did not have (non-slip mat) in place in her wheelchair and should have had it in place since it had been a previously implemented fall prevention intervention. V17 stated that staff was re-educated to check above and underneath R38's wheelchair cushion to ensure (non-slip mat) is in place.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 30722 Based on observation, record review and interview the facility failed to ensure psychotropic medications given on an as needed basis were not prescribed more than 14 days for 1 resident (R27) of 5 residents reviewed for unnecessary medications in a total sample of 29. Findings include: The facility's Policy / Procedure regarding Treatment/Services for Mental/Psychosocial Concerns dated 11/18/21 documents, A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. R27's Physician Order Sheet (POS) dated May 30, 2024 documents R27 is prescribed Lorazepam 0.5 milligrams by mouth every eight hours for anxiety. On 05/28/24 at 9:38 AM R27 was observed laying quietly in her bed on her left side. R27 was asleep and having no behaviors. On 05/28/24 at 12:23 PM, R27 was noted laying in her bed quietly, having no behaviors. On 05/30/24 at 11:09 AM, R27 was sitting in a wheelchair in the dining room at a table with two other residents and a staff while eating her lunch independently. R27 was not noted to have behaviors. On 05/30/24 at 11:07 AM V18, Certified Nursing Assistant, stated R27 sometimes hallucinates but is not aggressive nor displays self-injurious behavior. On 05/30/24 at 1:00 PM, V8, Licensed Practical Nurse/LPN, stated R27 had behaviors when she was new to the facility and the environment was different to her, however, typically her behaviors are an indicator of the beginning of a urinary tract infection or sometime similar. R27's Medication Administration Records document the last time she was administered Ativan on an as needed basis was February 15, 2024. A Note to Attending Physician/Provider documents R27 has an as needed (PRN) psychotropic order for Ativan 0.25 mg (milligrams) q8h prn (every eight hours as needed). Previously documented stop date of 04/23/24 will expire soon. 6 months is handwritten into the area for duration and dated 04/18/24. On 05/30/24 at 2:07 PM, V17, LPN, stated, It is not in our policy for a PRN psychotropic to not be ordered for more than 14 days, but it is our practice.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 31283 Based on interview and record review, the facility failed to ensure their Antibiotic Stewardship program was implemented. this failure has the potential to affect all 62 residents residing at the facility. Findings include: The facility's Antibiotic Stewardship Program policy (undated) documents the following: Infection Preventionist will encourage and educate staff to use McGeer's definitions of infections. Standards of infection observation are checking for signs observed and/or resident has a change of condition. The following steps will be implemented: monitor vital signs, monitor intake and output for 48 hours, assessment of lung sounds, and assessment of other signs of infection and update the physician and family. If UTI (urinary tract infection) is suspected, then 48 hour watch will be implemented by monitoring temperature, intake and output, urine color and character, pain assessment and changes in mental status using McGeer's definition as a guide. On 05/29/24 at 09:20 AM, V3 (Registered Nurse/Infection Preventionist) stated the facility does not implement any protocols to review clinical signs and symptoms and/or laboratory reports prior to implementation of an antibiotic for a resident. V3 stated the facility does not utilize any assessment tools or management algorithms to determine if an antibiotic is warranted, We just call the doctor and get an order for an antibiotic if we believe one is needed. The facility's Long Term Care Facility Application for Medicare and Medicaid, Form 671, dated 05/28/24 and signed by V1 (Administrator), documents 62 residents currently reside in the facility.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. 33970 Based on document review, observation and interview, the facility failed to ensure call lights were equipped to communicate directly to staff. This failure has the potential to affect all 62 residents residing in the facility. Findings include: The Software User Guide dated 2020 documents the web-based application is designed for nurse call and wander management use for Independent and Assisted Living facilities. The Guide documents to log-into the application with username and password. When the Alarms (nurse call or wander alarms) are activated, the computer will make a sound and display the location of the alarms. On 5/28/24 at 10:58 AM, R25 stated, I have to help when I go number two. I have waited up to 70 minutes for them (staff) to respond to my light. I would say the average wait time is between 30 minutes to 70 minutes. On 05/28/24 11:10 AM, R17 stated, The call light response time could be better. Especially in the morning when they are so busy. Sometimes you have to wait a really long time for help. On 5/29/24 at 11:45 AM, V10 Registered Nurse) demonstrated at the nurse's station a device called Code Alert which the screen will light up a resident's room number when the nurse call is activated or identify a resident's location if the wander guard alarm is activated. V10 stated, the computers will also notify the Nurses and/or Certified Nurse Aides (CNA) in the same manner. V10 stated, You (Nurses and CNA's) have to be at the desk (nurse's station) or at their computer to know if a resident needs assistance. On 5/29/24 at 12:00 PM, V12 (Physical Therapist) and V13 (Occupational Therapist) stated call light response time could be a lot better especially when a resident is toileting. V13 stated, We (Therapy) used to be able to help with call lights and toileting but ever since they switched to this new system, we are not alerted to when they (nurse calls) are on. On 5/29/24 at 1:34 PM, R25's nurse call was activated. At 1:37 PM, V17 (Licensed Practical Nurse) was observed to enter R25's room and state Music is in the Activity Room at 2:00 PM. V17 did not address and/or was not aware the nurse call was activated. On 5/29/24 at 1:45 PM, V14 (CNA), V15 (CNA), and V16 (CNA) were observed in the [NAME] Hall with a computer and demonstrated the use of the nurse call system. A call light was activated; an alert was displayed with the room number and location and a sound was heard. V16 stated, If we are not at the computer, we turn the sound on the computer up, but we still have to come out and look to see where the alarm is. On 5/29/24 at 1:55 PM, V8 (Licensed Practical Nurse/LPN) stated the computers time out (of the nurse call/wander guard software application) in one or two hours. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/29/24 at 1:55 PM, V5 (LPN) stated, If a call light (nurse call) is shut off in the room, it's still on in the system and we have to restart the system. Sometimes the call light gets stuck on, and we have to restart the system. It's (software application) kinda squirrely sometimes. It worked a lot better when we could just see the lights. On 5/30/24 at 9:45 AM, V1 (Administrator) stated if the wi-fi or power is lost, the facility has bells to give the residents and 15-minute checks are conducted. On 5/30/24 between 10:29 AM and 10:40 AM, two computers in the South Hall, one computer in the [NAME] hall and one computer in the East hall displayed two alarm notifications (1 notification on for 18 minutes in 3 North bathroom, 1 notification on for 9 minutes in 7 [NAME] bathroom) although no sound was heard. On 5/30/24 at 10:40 PM, V18 (CNA) stated, The volume was turned down because it's annoying. The following observations lacked nurse call monitoring by a nurse or CNA: The North Hall- on 5/28/24 between 10:20 AM and 11:00 AM, 12:00 PM and 12:30 PM; On 5/29/24 between 11:45 AM and 11:59 AM, 12:10 PM and 1:30 PM - 1:39 PM; 5/30/24 between 9:29 AM and 9:35 AM and 10:34 AM. The East Hall- on 5/29/24 at 1:40 PM and 5/30/24 at 9:29 AM. The South Hall- 5/29/24 at 1:29 PM and 5/30/24 at 9:28 AM. The Resident Census dated 5/28/24 documents that 62 residents currently reside in the facility.