

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/17/2026
NAME OF PROVIDER OR SUPPLIER  Hillcrest Retirement Village		STREET ADDRESS, CITY, STATE, ZIP CODE  1740 North Circuit Drive Round Lake Beach, IL 60073	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, interview, and record review the facility failed to ensure R1 was provided care that enhanced the quality of life for 1 of 4 residents reviewed for Resident Rights in the sample of 4. The findings include: On 02/17/2026 at 9:50AM, R1 was sitting in her room in an overstuffed reclining chair. On 02/17/2026 at 9:31AM, V1 Administrator said, R1 did not like the tone of voice V3 CNA-Certified Nursing Assistant used when providing care. R1 felt like it was condescending and reported it to me. V3 CNA received disciplinary action. V3 CNA's Disciplinary Warning Notice dated 01/14/2026 shows, Discourteous behaviors to resident.</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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