STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146130	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Retirement Village	1740 North Circuit Drive Round Lake Beach, IL 60073

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation and interview the facility failed accommodate a residents needs and preferences. This applies 1 of 26 residents (R30) reviewed for resident rights in the sample of 26.The findings include:On 8/25/25 at 9:13 AM, during initial tour, R30 was observed in her wheelchair leaving the dining room. R30 said she's having problems with R121 (her roommate). R30 said R121 gets jealous when she has visitors and says inappropriate things to her. I don't have to put up with this and I don't want to go back to my room.On 8/25/25 at 11:25 AM, R30 was in the dining room for the noon meals. R30 said the facility talked about moving rooms, but I shouldn't have to move, she should. I like my room. R30 said she feels uncomfortable when R121 has behaviors toward her.On 8/25/25 at 1:35 PM, R121 was lying in her bed, crying. R30 (her roommate) was sitting next to her in her wheelchair, holding her hand trying to console her. V10 and V11 (Both Certified Nursing Assistant's) came into the room to transfer and provide care to R30. R121 was calling out for R30 Are you here, don't leave me, repeatedly to R30. R30 said I'm not leaving, I'm going to lay down. R121 continues to call out, crying, and R30 in her bed trying to nap. V9 and V10 did not intervene or re-direct when R121 to call out for R30. On 8/26/25 at 12:21 PM, V15 (R30's spouse) said he reported his concerns to management regarding R121's behaviors affecting his wife. V22 said the other night R30 called him 15 times upset about her roommate issues.On 8/26/25 at 1:19 PM, V2 Director of Nursing (DON) said V15 (R30's spouse) reported R121's behaviors are affecting his wife. R121 is driving R30 insane and it's not fair to R30. A room change was discussed but there were some concerns about R121 could follow R30 in the facility and the behaviors would continue.On 8/26/25 at 1:44 PM, V6 (Social Services) said R121 hovers over her R30, causing R30 to get upset. V15 reported concerns about R121's behaviors affecting his wife (R30) and wants more boundaries and limits to be put in place to protect his wife.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a female resident was shaved and free of facial hair for 1 of 26 residents (R1) reviewed for Activities of Daily Living (ADLs) in the sample of 26.The findings include:On 8/25/25 at 10:26 AM, R1 was in the dining room drinking coffee. R1 had prominent whiskers covering her chin.On 8/26/25 at 10:40 AM, V16, Certified Nursing Assistant (CNA), said all residents gets a shower twice a week and they include shaving for men and women.On 8/26/25 at 1:40 PM, V19, CNA, said resident have a shower at least twice a week and shaving is included.On 8/27/25 at 10:32 AM, V1, Administrator said shaving takes place on shower days.R1's current care plan provided by the facility shows R1 has an ADL self-care performance deficit and has limited physical mobility. R1's Minimum Data Set (MDS) dated [DATE] shows R1 has severe cognitive impairment and requires substantial/maximal assistance with personal hygiene, including shaving.The facility's Grooming a Resident's Facial Hair Policy (undated) shows it is the practice of the facility to assist residents with grooming facial hair to help maintain proper hygiene.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review the facility failed to have pressure relieving interventions in place for residents at risk for pressure injuries for 2 of 6 residents (R5 and R30) reviewed for pressure injuries in the sample of 26.The findings include:1. R5's Medication Review Report printed on 8/26/25 showed an order for an air mattress and it was to be on at all times. On 8/25/2025 at 2:06 PM, R5 was in bed. There was an air mattress pump hanging on the foot of R5's bed. The lights on the air mattress pump were off and the pump was unplugged. On 08/26/2025 at 1:42 PM, R5 was in bed. The air mattress pump on the foot of the bed remained with the lights off and unplugged. On 08/27/2025 at 9:01 AM, V13 Licensed Practical Nurse said an air mattress pump is a pressure relieving intervention. R5's Braden Scale for Predicting Pressure Sore Risk with an effective date of 8/18/25 showed R5 was at risk for pressure injuries. R5's care plan with a revised date of 8/19/25 showed R5 had the potential for skin impairment. Listed under interventions was an air mattress. 2. On 8/25/25 at 1:35 PM, V10 and V11 (both Certified Nursing Assistants/CNAs) transferred R30 into her bed with the mechanical lift and provided incontinence care, The CNAs positioned R30's feet on the mattress and did not apply the protective boots. A bright colored sign was posted on the wall above her bed with a turning schedule and cradle boots on at all times when in bed. On 8/26/25 at 12:33 PM, V8 Registered Nurse (RN) said R30 is at risk for pressure, dependent on staff for cares and should have her protective boots applied when in bed. R30's current care plan shows has potential impairment to skin integrity related to fragile skin. Interventions include air mattress, wheelchair cushion and protective boots while in bed. The facility's undated Pressure Injury Prevention and Management Policy states, the facility shall establish and utilize a systemic approach for pressure injury prevention and management, starting with prompt assessment and treatment including efforts to identify risk, stabilize, reduce or remove underlying risk factors, monitor the impact of the interventions, and modify the interventions as appropriate .interventions will be implemented for all residents who are assessed and considered at risk .

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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 ensure a catheter drainage bag was maintained below the level of the bladder for 1 of 4 residents (R11) reviewed for catheters in the sample of 26. The findings include:On 8/25/25 at 12:53 PM, R11 was in the dining room sitting in her wheelchair. R11's indwelling urinary catheter drainage bag (leg bag) was attached to the top of her thigh in a position which did not allow for gravity to aid with drainage. The tubing was short and there was no slack in the tubing. On 8/26/25 at 1:40 PM, V19, Certified Nursing Assistant (CNA), said the urinary catheter drainage bag should be below the waist to prevent Urinary Tract Infections (UTIs)/infections. R11's current care plan provided by the facility shows R11 has a history of frequent UTIs. R11 has an indwelling urinary catheter, and the drainage bag and tubing should be below the level of the bladder. R11 is at risk for developing an infection due to the presence of the indwelling catheter.The facility's Catheter Care Policy (undated) shows drainage bags should be located below the level of the bladder to discourage backflow of urine.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview and record review the facility failed to implement interventions and provide services for a resident who is displaying increased behaviors of anxiety who has a diagnosis of dementia. This applies to 1 of 5 residents (R121) reviewed for dementia in the sample of 21.The findings include:R121's face sheet shows she has diagnoses including unspecified dementia, moderate with anxiety, anxiety, hypertension, and muscle weakness.On 8/25/25 at 11:27 AM, R121 was observed sleeping in her room.At 12:09 PM, R121 remained sleeping in her room. At 12:10 PM, V10 (Certified Nursing Assistant-CNA) delivered R121's room tray. Loud yelling was heard from R121's room from the hallway. R121 was yelling out loud Stay out of my life, Get out of it. I can do what I want. GET OUT. V10 left the room and said she was going to tell V7 (Registered Nurse-RN). R121 continued to yell loudly Get them out of here. V7 came to R121's room and attempted to re-direct her but she continued to yell and was agitated. V7 said R121 is normally not like this, I think she has urinary tract infection. V7 said this morning staff reported R121 said the staff were trying to kill her. R121 is normally very sweet and pleasant. When residents have increased behaviors, we try to rule out a urine infection and notify the physician.On 8/25/25 at 12:26 PM, V10 (CNA) said R121 has behaviors when she gets upset, she screams, cries and can be difficult to redirect at times.On 8/25/25 at 1:35 PM, R121 was lying in her bed, crying. R30 (her roommate) was sitting next to her in her wheelchair, holding her hand trying to console her. V10 and V11 (Both Certified Nursing Assistant's) came into the room to transfer and provide care to R30. R121 was calling out for R30 Are you here, don't leave me, repeatedly to R30. R30 said I'm not leaving, I'm going to lay down. R121 continues to call out, crying and upset. R30 trying to console and reassure R121 with the privacy curtain closed. V9 and V10 did not intervene or approach R121 while she was displaying behaviors and continued to provide care to R30. R121 was tearful and crying when this surveyor left the room, asking for a kiss. 08/26/25 at 8:58 AM, R121 was wandering in her room, pacing in her room and restless.On 8/26/25 at 9:00 AM, V12 (CNA) said R121 has behaviors, she cries, hallucinates, she misses her family and needs a lot of reassurance. R121 had an episode of delusions this morning, she's not aggressive and enjoys exercise groups.On 8/26/25 at 10:12 AM V8 (Licensed Practical Nurse-LPN) said R121 is very emotional, confused, worries a lot, hallucinates, and usually she is easily redirected. R121 is very protected over R30 her roommates, she likes to take care of R30. Staff should attempt to get R121 out of her room, try to distract and intervene when she is having behaviors. R121's family stopped coming frequently because her behaviors would increase when they leave.On 8/26/25 at 1:19 PM, V2 (DON) said R121's has behaviors, she's always sad, crying and anxious. We have struggled with her behaviors. Staff should redirect, distract, and involve her in activities. R121's family requested her antidepressant medications to be decreased and when that happened, she had increased behaviors. Family as of recent were agreeable to increase her antidepressant. V15 (R30's spouse) reported R121's behaviors are affecting his wife.On 8/26/25 at 1:44 PM, V6 (Social Services) said R121 gets very anxious and nervous, she hovers over her roommate. R121's family requested her anti-depressant to be decreased and her behaviors increased. R121's family recently agreed to increase her anti-depressant and we were waiting to see if her behaviors decreased. R121 tends to hover over her roommate (R30) and triggers behaviors for both. V15 (R30's spouse) has reported R121's behaviors towards R30 and requested for boundaries and limits be put in place. Staff should intervene when R121 is becoming obsessive with R30 and try to redirect her and provide assurance. Staff should engage, encourage activities and refer her to psych with increased behaviors.R121's Social Services note dated 8/18/25 documents V22 (R121's daughter) was called to discuss concerns of her anxiety. R121 is very pre-occupied with R30 and tends to (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hover over her.R121 also becomes agitated is she observes R30's husband interact with others. V18 agrees, her mom (R121) is very anxious and get pre-occupied with multiple things. will continue to monitor for changes, aid resident with concerns and provide re-assurance and reminders.R121's nurses note dated 8/18/25, documents at heard yelling from her room get away. (R121) standing over R30's bed, crying. V8 (LPN) explained R30 does not want to be bothered and wants to sleep. (R121) she's mad at me.The progress notes shows there was no documentation on 8/25/25 of R121's increased behaviors or interventions implemented for her behaviors. R121's current care plan shows her cognition is moderately impaired, she is dependent on staff for emotional intellectual, physical and social stimulation. She requires invites and reminders. Staff should encourage her to attend group activities and engage in conversation.R121 appears to worry a lot, she obsesses over her roommate and hover over her in her room upsetting the roommate to the point roommate will yell at her to leave her alone. This will then lead to anxiety on her part. Interventions include consult with pastoral care, social services, and psych services, encourage participation, increase communications between, family, care givers, monitor response.The facilities undated Dementia Care Policy states, It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs or is diagnosed with dementia, to meet his or her highest practical physical, mental and psychosocial wellbeing. the facility will assess, develop, and implement care plans.the care plan interventions will be related to each resident's individual symptomology and rate of dementia.,. Care and services will be person-centered and reflect each residents' individual goals.individuated, non-pharmacological approaches to care will be utilized to include meaningful activities. appropriate referrals will be made if current interventions are ineffective or resident shows a decline in psychosocial, mood or behavioral status.

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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. Based on interview and record review the facility failed to ensure a resident received their routine medication for 1 of 5 residents (R88) reviewed for pharmacy services in the sample of 26.The findings include:R88's Face Sheet printed on 8/26/25 showed R88 was diagnosed with chronic obstructive pulmonary disease (COPD). It was listed as R88's principal diagnosis. R88's Medication Review Report printed on 8/26/25 showed an order for ipratropium-albuterol inhaler to be given four times a day for COPD. On 8/26/25 at 9:30 AM, R88 said about a week ago he missed two doses of his inhaler medication. R88 said he was not sure why he missed two doses of his inhaler medication.R88's Medication Administration Record for August 2025 showed on 8/18/25 the 3:00 PM and 8:00 PM doses of ipratropium-albuterol inhaler did not indicate R88 received the medication. For the 3:00 PM and 8:00 PM doses, there was a code that referred to progress notes. The corresponding progress notes dated 8/18/25 showed the medication was not available for the 3:00 PM and 8:00 PM doses.On 8/26/25 at 10:00 AM, V14 (Licensed Practical Nurse) said on 8/18/25 she went to give R88 his scheduled ipratropium-albuterol inhaler and it was not in the medication cart resulting in R88 not receiving doses. V14 said she re-ordered the medication. V14 said it was her understanding the inhaler was found the next day at the end of R88's bed. V14 added the inhaler should have been in the medication cart.On 08/26/2025 11:21 AM, V2 (Director of Nursing) said R88's inhaler was misplaced and it should have been stored/kept in the medication cart.R88's Care Plan with a revision date of 11/6/24 showed R88 had COPD. Listed under interventions was to give medication as ordered. The facility's Medication Administration Policy (undated) showed medications are administered as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure controlled medications were secured with a dual lock system and failed to discard an outdated insulin pen which applies to 2 of 2 residents (R61, R93) reviewed for medication storage in a sample of 26. The findings include: 1 On 8/26/25 at 11:10 AM, V8 Licensed Practical Nurse (LPN) opened the 100-200 hall medication room. The resident medication refrigerator had an open lock hanging on the latch of the refrigerator. The refrigerator door had a new box or R93's Methadone Oral Concentrate (Schedule II controlled substance) 10 milligrams per milliliter (mg/ml). V8 stated the refrigerator should be locked. R93's Physician Orders printed on 8/26/25 showed R93 has an order for Methadone Oral Concentrate 10 mg/ml to be given 4 ml by mouth one time a day for pain. On 8/26/25 at 11:30 AM, V2 Director of Nursing stated the medication room refrigerator should be locked. The facility's Medication Storage Policy dated 2025 (copyright) showed the facility will provide safe and effective storage of all drugs/narcotics and biologicals in a locked storage area under proper temperature controls with limited access by authorized personnel consistent with state or federal requirements and professional standards of practice. 2. On 8/26/25 at 9:13 AM, R61's Humalog KwikPen (insulin) was labeled with a written expiration date of 8/23/25. V18, Registered Nurse (RN), said the insulin pen should have been thrown away. V18 said the nurse labels insulin with a use by date which is 30 days from when it is opened. R61's admission Record dated 8/26/25 shows he has a diagnosis of diabetes. R61's Medication Review Report shows he has an active order for Humalog KwikPen to be administered before meals and at bed time as per a sliding scale. The facility's Insulin Pen Policy (dated 7/2022) shows insulin pens should be disposed of after 28 days.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 1 residents (R11) received routine dental care in the sample of 26 reviewed for dental services.The findings include:On 8/25/25 at 10:13 AM, V17, R11's husband said R11 has been residing in the facility for over two years and has not received any preventative dental care. On 8/27/25 at 10:12 AM, V17 said he was notified in writing in early July 2025 that a dentist would come to the facility and see R11 if he enrolled her in the program. V17 said R11 has not seen a dentist since she was admitted .R11's admission Record dated 8/25/25 shows she was admitted to the facility on [DATE]. R11's current care plan provided by the facility shows R11 has oral/dental health problems.On 8/27/25 at 9:56 AM, V1, Administrator, said R11 has not seen a dentist since she was admitted to the facility. V1 said R11 was eligible for the dental program, but she was not enrolled in the program, so she did not receive dental care.On 8/27/25 at 11:21 AM, V2, Director of Nursing (DON), said the facility has no dental policy, it does not exist. On 8/27/25 at 1:32 PM, V2 said R11 was not offered enrollment in the dental plan upon her admission, she was Medicaid pending and should have been told about it after she was on Medicaid.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to ensure the sanitizing solution level was within range to sanitize food contact surfaces and failed to ensure expired bread was discarded. This applies to all residents residing at the facility.The findings include:On 8/25/25 at 9:30 AM, the sanitation solution in the bucket was checked for sanitation level. V3 (Dietary Manager) took a strip and checked the solution, after 10 seconds it registered as light orange. V3 then compared the strip quat color coded level-the light orange was 0 level. V3 placed the strip again in the sanitizing solution and this time V3 waited for approximate 20-30 seconds. The strip still registered as light orange which was still in the 0' level. V3 said the sanitizing solution should be in the 200's-400's which the strip should turn dark blue to be able to sanitize food prep areas to prevent foodborne illness. V3 also said the sanitizing solution was only good for 2 hours, it needed to be replaced now. At 12 PM, V5 Dietary Aide said she mixed the sanitizing solution at 6AM, it was supposed to be replaced at 8AM to be effective.The Facility Policy on Manual Sanitizing documents: Equipment. Utensils and table wares will be washed and sanitized. Quat 200-400 ppm concentration changed every 2 hours.2. On 8/25/25 during the kitchen tour, the bread cart was checked (loaves of bread, burger buns and hotdog buns.) A bag of hotdog bun was noted to have a date of 8/8/25. V3 said all bread packs were dated on the day of delivery and discarded within six days. V3 said the bun should have been discarded last 8/15/25. (6 days after delivery)The 671 CMS form dated 8/25/25 show there were 126 residents residing at the facility.The Facility Policy on Labeling and Dating of foods documents, to decrease the risk of foodborne illness and to provide the highest quality food is labeled with the date received the date open and the date by which the item should be discarded

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP) for 6 of 26 residents (R8, R46, R65, R11, R3 and R64) reviewed for infection control in the sample of 26.The findings include: 1. On 8/25/25 at 9:38 AM R8's room had no EBP signs on or near the entrance to his room and no Personal Protective Equipment (PPE) was located outside of his room. R8's admission Record dated 8/25/25 shows R8 has a diagnosis of gastrostomy status. R8's Order Summary Report dated 8/25/25 shows he receives enteral nutrition via a gastrostomy tube and a current order from 3/11/25 for EBP. 2. On 8/25/25 at 9:45 AM, R46's room had no EBP signs on or near the entrance to his room and no Personal Protective Equipment (PPE) was located outside of his room. R46 said he has had a (urinary) catheter for at least three months. R46's Order Summary Report dated 8/25/25 shows a current order for EBP from 1/3/25 and a current order from 3/18/25 to change his indwelling urinary catheter every month. 3. On 8/25/25 at 10:06 AM, R65's room had no EBP signs on or near the entrance to his room and no Personal Protective Equipment (PPE) was located outside of his room. R65 had a bandage to his left lateral knee. R65 said he got an infection from a leg brace he was wearing at another facility. R65's Order Summary Report dated 8/25/25 shows a current order for wound treatment to his left lateral knee wound and a current order for EBP. R65's Wound Evaluation & Management Summary dated 8/20/25 shows he has a stage 4 pressure wound on his left, lateral knee. 4. On 8/25/25 at 10:13 AM, R11's room had no EBP signs on or near the entrance to her room and no Personal Protective Equipment (PPE) was located outside of her room. V17, R11's husband, said R11's (urinary) catheter drainage bag is changed to a leg bag during the day. R11's Order Summary Report dated 8/25/25 shows a current order from 10/16/24 for EBP and a current order from 6/12/25 to change her indwelling urinary catheter every month. On 8/26/25 at 12:45 PM, V4, Infection Prevention Nurse, said any resident with a chronic wound, a g-tube, or an indwelling urinary catheter should be on EBP. 5/6. On 8/25/25 at 10:20 AM, there was no Enhanced Barrier Precaution (EBP) sign posted on/around R3 and R64's room. The Facility's Matrix (802) printed on 8/25/25 showed R3 and R64 reside in the same room. R3's Physician orders printed on 8/27/25 showed R3 has orders for G-tube (feeding tube) maintenance and tube feeding bolus feeding. R64's Physician orders printed on 8/27/25 showed R64 has orders for sacral wound treatments and dressings. The facility's EBP Policy dated 2025 (copyright) showed residents with medical devices including catheters and feeding tubes and residents with chronic wounds need to be on EBP precautions. Residents on EBP isolation need to be identifiable they are on the isolation status.