STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Change of Ownership Licensure Survey Investigation of Complaints: 1994151/IL112880: 330.1310 a)b)2)c)1)g)j) 1991662/IL110181: 330.1310 a)b)2c)1)g)j) 1897364/IL107240: No deficiency 1893524/IL103029: No deficiency	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 3 Licensure Violations 330.710a) 330.720b) 330.3370d) 330.4240a) Section 330.710 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part. Section 330.720 Admission and Discharge Policies b) No resident determined by professional evaluation to be in need of nursing care shall be admitted to or kept in a sheltered care facility.	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 1	S9999		

Neither shall any such resident be kept in a distinct part designated and classified for sheltered care.

Section 330.3370 Stairways, Vertical Openings, and Doorways

Every building shall meet the following requirements:
d) All required exit doors shall swing outward, be equipped with panic hardware, and be free of any obstruction, chain, locking or holding device. Each exit door and each door in an exit passageway shall be at least three feet, eight inches in clear width. If the doors have no latching mechanism, panic hardware may not be required.

Section 330.4240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

This REGULATION was not met as evidenced by:

#1. Based on observation, interview and record review, the facility failed to:

A. Turn and reposition residents per facility policy for R3, R15, and R16.

B. Follow recommended swallowing precautions for R10 and R11.

C. Failed to follow their discharge policy and physician order to discharge a resident with a Stage 4 pressure ulcer to a LTAC (Long-Term Acute Care) facility until the wound was healed for R6.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 2	S9999		

D. Failed to follow their policy on life/care plan re-assessments. Failed to follow the policy and include resident families in the re-assessment for R1, R3, R4, R5, R6, R7, R8, R9, R12 and R13.

The findings include:

A. On September 17, 2019 from 8:00AM until 11:35AM in House 3 the following residents were observed seated in specialty geriatric chairs in the main living/dining room of the house. R3, R16, and R15 were all noted to be totally dependent upon staff for all activities of daily living and for transfers. R3, R16 and R15 were not monitored or checked for urinary or bowel incontinence nor were these residents provided position changed during this time.

R3 was noted to be sitting in an adult geriatric chair with a mechanical lift transfer sling underneath R3. R3 was noted to be dependent on direct care staff for position change. R3 was not able to assist the staff in position change and was totally dependent on staff for movement. R3 was again observed sitting in the same position from 11:40AM until 12:10PM still sitting on the mechanical lift transfer sling.

R16 was observed in the main living room/dining room of House III sitting on a mechanical lift transfer sling in an adult specialty chair. R16 is totally dependent upon direct care staff for transfers, position changes, and activities of daily living. R16 was not provided a position change nor checked and monitored for urinary and bowel incontinence from 8:00AM to 11:35AM and from 11:40AM to 12:10PM.

R15 was also observed on September 17, 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

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S9999	Continued From page 3	S9999		

in House III from 8:00AM until 11:35AM in the living/dining area of the facility. R15 was also noted to be sitting on a mechanical lift transfer sling and was also noted to be totally dependent on direct care staff for transfers, position change and activities of daily living. During this time, R15 was not given a position change nor was R15 checked for bowel and bladder incontinence.

V16 and V15 (Resident Specialist/Care Givers) were assigned to House III and spent the time from 8:00AM to 11:35AM feeding residents and cleaning the tables and areas after the breakfast meal. V16 then proceeded to provide activities to residents and then proceeded to get the residents ready for lunch. V10 (Certified Nurse Aide/ floater) did provide some feeding assistance to residents in House III, however R3, R15, and R16 were not removed from the living/dining area during this time.

Facility's policy and procedure undated entitled "Turning and Reposition Program" documents, "Every resident will be re-positioned at least every two hours per the program." "Each resident will be assessed, and a determination made as to the frequency of the turning needed. Residents who need more frequent turning and re-positioning will have this frequency identified on their plan of care." "All residents who are unable to reposition, toilet, or turn themselves will be placed on the turning program."

B. R11's POS (Physician Order Sheet) shows a physician order, dated 1/17/19, for, "ST (Speech Therapy) evaluation for therapy. Diagnosis: Difficulty Swallowing." Physician order shows "Change patient to pureed diet with Nectar Thick-it ...."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

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S9999	Continued From page 4	S9999		

Speech pathology progress notes, dated 1/21/19 and 1/25/19, shows staff were provided training on R11's swallowing precautions by the speech pathologist. The 1/21/19 progress note shows, "Education provided to CNA (Certified Nursing Assistant). Verbal report provided to nursing acknowledged. A (Assessment)), Mild oral dysphagia, dementia/cognitive communication deficits ...."

On 9/16/19 at 12:15 PM, Speech Language Pathologist document titled "R11: Safe Swallow Tips," dated 1/27/19 hung on the wall of the kitchen near the dining table. The document provided the following instructions regarding R11, "1. Sit up 90 degrees greater in wheel chair. 2. Sit to her right side to feed her from the side rather than the front. By giving her food this way, it is more like she is feeding herself. Give liquids while sitting this way also to allow her to swallow more safely. 3. Alternate taste, texture, and temperatures. This will help her clear any left overs in her mouth and reduce the risk of choking because she will be aware of the food/drink. 4. Use metal utensils and hard cup. 5. Slow rate. Bite size 1-1 ½ teaspoons. 6. Diet upgrade to (M/S) Mechanical Soft solids, NTL (Nectar Thick Liquids, thin liquid water between meals. *Continue current NTL / pureed until MD (Medical Doctor) order processed."

On 9/16/19 at 12:37 PM, R11 was initially fed a few bites of her pureed lunch by V6 (Resident Specialist/Caregiver). V6 stood on R11's left side and fed R11 a few bites of pureed food using a white plastic spoon and then walked away. No liquid was offered. At 12:43 PM, V3 (Activities Director) sat on R11's right side and fed R11 several bites of pureed food using the white

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5	S9999		

plastic spoon, however only offered one sip of juice at the end of offering all the food. At 12:46 PM, V3 left R11 and V6 returned to feed R11 standing at R11's left side and reaching across R11 with V6's left hand to offer bites of food the entire time she fed. Using the white plastic spoon, V6 quickly offered R11 very large bites of the same food item until the food item was finished. V6 then moved to the next food item, quickly offering very large bites as soon as R11 swallowed the previous bite. V3 continued to quickly feed R11 one food item at a time until each was finished and only offered one sip of liquid throughout the time V3 fed R11 her food. R11 was quickly fed 100% of her pureed fruit and was then quickly fed 100% of her juice, less the two prior sips during the meal, between 12:54 and 12:55 PM. R11 was then quickly fed 100% of her milk between 12:55 PM and 12:56 PM. R11 was offered the beverage again as soon as R11 swallowed the previous mouthful.

Nursing progress notes, dated 3/10/19, show R11 was observed "continuously coughing, attempting to cough up food and phlegm. Resident unable to cough food up, Heimlich performed and not successful. Breathing labored, SPO2 (Oxygen Saturation) 89% on RA (Room Air). Writer called 911 and sent resident to [hospital]"

Speech Therapy evaluation, dated 1/25/19, shows R10 had a diagnosis of sepsis secondary to right middle lobe aspiration pneumonia and a history of cerebralvascular accident, cognitive impairment, and oral cancer. The evaluation shows R10's had "¾ of maxilla surgically removed to treat a malignant tumor. Definitive maxillary prosthetic was used until anchor teeth were removed. Patient is edentulous, and defect is open resulting in an increased risk of nasal

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	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

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S9999	Continued From page 6	S9999		

regurgitation, reduced bolus control, reduced intraoral pressure and increased risk of dehydration and complications associated with aspiration." The evaluation shows, "Staff present for training this day regarding general swallowing anatomy, patient specific safe swallowing compensatory strategies and clinical signs/symptoms of aspiration." The evaluation shows, "Teaching Tools Used/Given: Swallowing strategies/precautions."

Speech Language Pathologist document titled "Swallowing Tips" for R10, dated 1/27/19, was hung on the wall of the kitchen near the dining room table. The document showed, "1. Sit upright pillow behind lower back. Stay upright at least 60 minutes after eating. 2. Staff sit to his right front side. This allows you to feed him on his BEST side to help him control the food better and more safely. 3. Use a metal spoon. *He can feel the weight and temperature from the metal spoon. 4. Alternate taste/temperature. *We want to keep his mouth awake as much as possible. Make sure the puree is nice and hot and he has a cool thick drink and/or a pudding or pureed fruit. Salty/sweet mix it up. 5. Take your time. Watch for R10 to swallow and let him know what you are feeding him when you are giving him a bite."

On 9/16/19 at 12:37 PM, R10 was independently eating his pureed lunch with a white plastic spoon. At 12:50 PM, R10 continued to independently feed himself his entire meal with the white plastic spoon. No staff assisted R10 with his meal.

On 9/16/19 at 12:48 PM, V5 (Resident Specialist/Caregiver) stated the staff always give residents on pureed diets the white plastic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

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S9999	Continued From page 7	S9999		

spoons for meals because some of the residents do not have teeth and the staff feel the plastic spoons are better than metal spoons for their mouths.

Program Service Plans, dated 4/18/19 and 7/7/19, show no evidence of R10's swallowing precautions or instructions as provided by their most recent speech pathology evaluations and treatments.

Program Service Plan and Care Plan Report, dated 7/8/19, show, R11 "has a history of dysphagia, is on pureed, nectar thick diet ... Has specific instructions to feed patient because of her dysphagia which are followed by staff."

On 9/18/19 at 12:00 PM, V2 (Director of Nursing) stated the nursing staff were provided an Inservice on thickened liquids and feeding residents, such as the need to sit down while feeding residents. On 9/17/19 at 11:52 AM, V2 stated V3 (Activities Director) should not be feeding residents because she had not received the training to feed residents. V2 stated there was no facility policy that indicates which staff can feed residents.

On 9/18/19 at 1:52 PM, V3 (Activities Director) stated she was recently asked recently by facility CNAs (Certified Nursing Assistants) to help feed residents during meals. V3 stated she was told only to feed the residents slowly and if they have swallowing difficulties, give small bites and thickened liquids. V3 was not aware of any specific swallowing precautions for any of the residents in House 2 including R10 and R11.

On 9/17/19 at 11:39 AM, V5 (Resident Specialist/Caregiver) stated he had worked at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

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S9999	Continued From page 8	S9999		

facility eight years and, to his knowledge, the only training he received on feeding residents at the facility was what he was taught in CNA school six years ago. V5 stated he was not aware of any residents specifically having swallowing precautions or instructions.

On 9/17/19 at 11:42 AM, V6 (Resident Specialist/Caregiver) stated she was not aware of R10 or R11 having any specific swallowing precautions or instructions.

On 9/18/19 at 11:46 AM, V8 (Resident Specialist/ Caregiver) stated she was not aware R10 or R11 had any specific swallowing precautions or instructions.

Facility document Weight Loss or Gain / Eating Disorder/ Swallowing Disorder, undated, shows, "7. When eating or swallowing problems are identified, the issue should be documented, and update of the ISP (Individual Service Plan) should be done including strategies."

C. On September 16, 2019, at 9:15 AM, V5 (Resident Specialist/Caregiver) and V10 (CNA Supervisor) provided incontinence care to R6 in her bed. V10 said R6 is unable to transfer between surfaces without the use of a mechanical lift device. V5 said R6 is wheelchair-bound, totally dependent on facility staff for ADLs (Activities of Daily Living) except for eating and is incontinent of bowel and bladder. V9 (LPN-Licensed Practical Nurse) said the home health nurse was scheduled to come to the facility on September 17, 2019 to do the dressing change on R6's right hip, but due to the dressing being soaked with urine, V9 had just changed the dressing on R6's right hip.

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	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

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S9999	Continued From page 9	S9999		

On September 17, 2019 at 9:36 AM V9 (LPN) said R6 has a history of developing pressure ulcers while residing at the facility. V9 said R6 is unable to make position changes without staff assistance, and the physician wrote an order on September 10, 2019 for facility staff to reposition R6 every 15 minutes.

The wound documentation for R6 shows the following:
On August 6, 2019 R6 had a Stage 3 pressure ulcer on her left buttock measuring 3.2 cm. x 3.0 cm. x 0.5 cm.
On August 15, 2019 R6 developed an unstageable pressure ulcer on her right lateral hip measuring 2.5 cm. x 2.5 cm. x 0.0 cm., in addition to the left buttock pressure ulcer.
On August 22, 2019, the facility documentation showed R6 continued to have the left and right hip pressure ulcers and developed a Stage 2 pressure ulcer on the left sacrum. The facility did not have measurements of the three pressure ulcers on August 22, 2019.

V25's (Wound Doctor) orders dated September 6, 2019 show, "1. Right hip with new infection today. 2. Please culture and I.D. (Infectious Disease) consult and IV Abx (Intravenous Antibiotics). 3. Surgery Consult. 4. Keep on air mattress w/pressure relief, no sitting. 5. Keep at LTAC (Long-Term Acute Care) until healed."

Facility documentation shows R6 was sent to the local hospital on September 6, 2019 per V25's (Wound Doctor) order. R6 returned to the facility on September 7, 2019 with an order for oral antibiotic medication.

On September 10, 2019 R6's wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

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S9999	Continued From page 10	S9999		

documentation shows, right lateral hip deteriorated to Stage 4.

On September 17, 2019 at 10:15 AM, V25 (Wound Doctor) said, "[R6] gets pressure ulcers for multiple reasons, including because she's very heavy and she's not mobile. She can't walk. Her left buttocks/hip area was a significant wound, but almost completely healed over during the summer. It was quite deep and quite difficult. Her right hip developed on August 23, 2019. We started intensive treatment with foam with increasing off-loading in the wheelchair. She needs to be in bed more. On September 6, the wound was getting worse with purulent drainage. I talked to [the family member] and [V2] (DON-Director of Nursing) and everyone was willing to have the resident admitted with clear instructions, including surgical consult, infectious disease consult and use of a specialized bed. I wanted her to go to rehab in a skilled nursing facility until the wound was healed. The family knew this, and the DON knew this. The hospital sent [R6] back to the facility and gave her an oral antibiotic. I was not consulted. Her wound required daily wound care at a higher level of care to include more turning times. I wrote an order for her to receive intravenous antibiotics, and surgical consult because I felt she needed that. When I wrote the order for her to go out of the facility it was because she needed daily wound care. Her wound had gotten worse. I did not want her to be at the facility at all. The facility does not have the level of care to turn her every 15 minutes like I ordered."
R6's undated face sheet shows R6 was admitted to the facility in February 2019 with a diagnosis of dementia, hypertension, cellulitis of the left forearm, and major depressive disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

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S9999	Continued From page 11	S9999		

R6's Program Service Plan dated July 9, 2019 shows R6 requires total assistance by facility staff for dressing, bathing, toileting, bladder and bowel continence, transferring, oral care, personal hygiene, mobility and ambulation, and evacuation. R6 requires a mechanical lift for transfers and is wheelchair-bound. R6's Care Plan Report Summary shows: "[R6] is total care. Is transferred to wheelchair via [mechanical lift] and assist of two staff. Patient is incontinent of bowel and bladder. Incontinence care rendered q (every) 2 hours. Patients has long history of depression. Pt. is very HOH. Gets very impatient when she cannot hear what is going on or an answer to her questions. Needs emotional support and reassurance. Does sit at lunch table with other residents and does do some table arts and crafts. Patients has history of ongoing wounds and pressure ulcers which are being treated per M.D order and continue to be followed daily. [R6] reposition q 2 hour while in bed. Wears heel protector boots daily. Pt can make her needs known. Usually quiet. Receives Xanax (anti-anxiety medication) and recently put on air mattress. Weight is static. Home health every Tuesday and Thursday for wound care."

The facility's undated Admission Contract shows: "[The facility] may terminate this Agreement, upon providing you or your Responsible Party thirty (30) days written notice, for any of the following events, as determined by [the facility]:
(2) You require care other than that which the residence is licensed to provide.
(3) You require care which is inconsistent with the residence's program statement and which the residence is not required to provide.
(5) Medical reasons as ordered by a physician."

The facility's undated Program Statement shows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 12	S9999		

"Discharge Process: [The Facility] Director or designee monitors the continued appropriateness of placement of a resident in the facility by obtaining feedback from direct care staff, on an ongoing basis. If the resident's needs are no longer being met, or if the resident's mental or physical condition has deteriorated to such a degree as to render the care program detrimental to the health, welfare or safety of the person or other residents, or if the resident requires a level of care that [the facility] does not provide, or if resident is no longer able to pay privately, [the facility] will provide 30 day written notice of discharge. ...If it is determined that, based upon discharge criteria, the resident is no longer appropriate for the current level of care, the [facility] Director, or designee, will assist the family in transferring the resident to a level of care that is appropriate for the resident."

The facility's Resident Discharge Policy, updated February 12, 2002 shows: "Subject: Resident Discharge. Procedure: 3. A resident may no longer be appropriate for placement if their medical condition required an on-going skilled care need, i.e., IV care, feeding tube ...: if they are deemed a threat to the safety to self or others due to behavior; if they can no longer meet the financial obligations of care."

The facility's Policy and Procedures for "Discharge from the Program" dated February 12, 2002 shows: "Policy: Residents will be discharged from the Alzheimer Program for the following reasons. 1. Urgent Discharge. Need for hospitalization due to acute illness or behavior that presents danger to self or others, or skilled care, such as isolation or IVs in another house. 2. Non-Urgent Discharge: B. Inappropriate placement in Alzheimer's Care Program due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 13	S9999		

but not limited to: 1. Need for skilled care (G-Tube, IVs). 3. Becoming bed-ridden unless on hospice. Procedure: Non-Urgent Discharge: A. Interdisciplinary team meets with family to discuss discharge from program, when discharge criteria is met. B. Give families a list of nursing homes deemed appropriate for the resident's altered care needs."

D) Facility document Resident Care Plan, dated 10/2016, shows nursing summaries are to be completed every two months to assess and record resident physical, behavioral, nutritional and ADL (Activities of Daily Living) status .... Resident/family/responsible parties invited to attend and participate in care plan reviews."

Facility document Alzheimer's Program Statement, dated 12/31/07, shows. "The Director of designee will perform a formal reassessment of residents semi-annually or when significant resident changes occur. Life plans will be reviewed and if necessary updated at this time. Families and residents will be invited and encouraged to participate in the development of the Life Plan. The [facility] Director or designee will review and approve all service plans along with the resident and/or the designated resident representative .... In addition, families are invited to be a member of the team that develops and revises the resident's Life Plan."

On 9/16/19 at 2:27 PM, V2 (Director of Nursing) stated all residents had an annual care plan reassessment recently and all families were called and invited to come in for a care plan meeting. V2 stated no families called requesting a meeting. At 2:40 PM, V2 stated she was not sure the facility offered/held any other care plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 14	S9999		

meetings for R1 other than the 10/7/14 and 10/23/18 care plans.

Review of R1's clinical record shows R1 was discharged from the facility on 6/16/19. The record shows R1 had service plan reviews on 10/7/14 and 10/23/18 with family present at both. The record failed to show any other service plan reviews, any other family involvement in R1's service plans, or documentation the family declined to participate in R1's service plans. On 9/12/19 at 4:05 PM, V18 (Family) stated R1 had not had a care plan offered to the family during the year 2019. V18 stated the last care plan that was offered by the facility was on 10/23/18 and the family had to initiate the meeting.

Review of R3-R9, R12 and R13's clinical records showed the residents did not receive care plan / life plan reassessments as per facility policy. The records failed to show the residents' families were contacted to participate in care plan / life plan reassessments as per facility policy.

2. Based on observation, interview and record review, the facility failed to follow facility smoking policies, failed to identify and supervise residents at risk for elopement per policy, failed to identify and minimize hazards related to resident movement, failed to repair facility exit alarms to prevent elopement, and failed to have functioning door locks and alarms to prevent potential elopement.

This applies to 14 of 14 residents (R5, R6, R7, R10, R11, R12, R13, R23, R33-R38) reviewed for accidents/incidents in a sample of 44.

The findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 15	S9999		

Facility census, dated 9/11/19, shows R5, R6, R7, R10, R11, R23 and R33-38 all live in House 2.

1. On 9/19/19 at 2:15 PM in House 2, there was a strong smell of smoke in V2's (Director of Nursing) office and conference room on the main floor near resident rooms. At 2:17 PM in the basement with V26 (Nurse), there was a very strong smell of smoke in the hallway. V14 (Maintenance Supervisor) was in the basement and stated the strong smell of smoke was because he was smoking, and the smoke came in the building. V14 stated he smokes at the base of the stairwell of the basement and identified the aluminum soda can tucked between the hand rail and cement wall outside the door at the bottom of the stairs. The can had used cigarette butts in the can. There was no odor of smoke outside at the bottom of the stairwell, but a very strong smell of smoke lingered in the basement. The basement hallway and door to the stairwell was directly over resident rooms in House 2. V26 stated the only area in the facility employees are allowed to smoke was in front of the facility near the parking lot.

Facility document, dated 10/1999, shows "[Facility] buildings are designated as 'No Smoking' buildings. Smoking areas of all facilities is designated and limited to the backyard/courtyard patios of each house. Ash tray bins will be provided."

2. Face sheet, undated, shows R7 was admitted to the facility on 1/24/2018. POS (Physician Order Sheet), dated 9/1/19-9/30/19, shows R7's diagnoses include dementia, developmental delay, diabetes, and anxiety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 16	S9999		

Facility Program Service Plan, dated 7/6/19, shows R7 had impaired memory and attention, a disorganized thought process, alcohol induced dementia, poor judgement, unable to make decisions, and "does wander on occasion mostly if there is another patient to do it with." The Plan of Care shows only fall prevention identified as a service needed by R7. R7's care plan report shows R7 has a tendency to walk too fast, and needs constant monitoring when he is up walking, and is usually re-directable as he is easily mislead by other residents.

Facility Elopement Risk Assessment shows the following:
1/31/18 - R7 was a new admission and has a history of elopement at his previous facility
7/8/18 - R7 tends to go out of building and walk in courtyard
9/13/18 - R7 continues to go out of building and walk in the courtyard, "able to get back inside himself. Staff continue to monitor him and redirect him."
11/8/18 - "Still goes out of the building to walk in courtyard .... Staff continues to monitor his whereabouts and supervise his walking outside."
5/19/19 - "R7 is not an elopement risk. Will monitor in courtyard with others. R7 does not try to go out of assigned area."
7/18/19 - "R7 is not an elopement risk. Does not try to go out of assigned area."

Nursing notes, dated 2/14/18 and 2/15/18, show R7 repeatedly stated he needed to leave the facility and exited out the front door with a visitor and the alarmed side door of the facility several times. Notes, dated 3/13/18, show R7 pulled the fire alarm next to the main entrance as he expressed the need to go home. Notes, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 17	S9999		

12/28/18, show R7 experienced increased wandering.

Facility document Attempted Elopement, dated 9/19/19, shows "On Sunday, September 15, 2019 at approximately 7:30 PM V2 (Director of Nursing) spoke with V24 (CNA-Certified Nursing Assistant) at [facility] who called to report R7 was outside the interior chain link green fence where he had entered through a gap by the pole and they could not get him back over the fence. R7 remained inside the perimeter fence of the [facility] property and was being directly supervised by the employee. R7 was able to return to the interior area and was escorted back into his house. At this time no report was made to the department as R7 remained on the property under supervision. At the end of business day on Thursday, September 19, 2019 during the change of ownership survey, the surveyors brought it to the attention of (V2) that on September 19, 2019 at 1:08 PM, V12 (Resident Specialist/Care Giver) said, "I work 3:00 PM to 7:00 AM. We didn't know that [R7] got out of the house. Someone from the neighborhood came to the building and told us he was trying to climb the facility's fence. We had to go outside to look for him."

On September 19, 2019 at 1:17 PM, V13 (Resident Specialist/Care Giver) said, "I am the floater CNA and I go from house to house. I spend most of my time in [R7's] house. The door doesn't lock in that house. I told [V10] (Resident Specialist/Care Giver Supervisor) and the supervisor about 3 months ago. We have a lot of wanderers in that house."

Nursing notes, dated 9/16/19, show, "V2 notified yesterday that staff found R7 outside the green

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 18	S9999		

fence by House 1. Staff contacted V2 to determine how to get R7 over fence. Staff was able to pull green fence. V14 (Maintenance Supervisor) notified to repair green fence."

On 9/16/19 at 10:33 AM, V14 was outside at the corner of the green chain link fence placing zip ties through the fence links and around the pole of the perpendicular fence to secure the chain link fence to the pole. V14 stated the staff called him the day prior when R7 was found in the off-limits backyard of House 1. V14 stated he and the staff believed R7 squeezed through the area he was securing by pushing the unattached chain link fence away from the pole which secured the perpendicular chain link fence. The yard behind House 1 was only accessible through a locked door in the chain link fence which was unlocked by V14. Behind House 1 was a cement stair well with nothing preventing an individual from attempting to descend the stair and remain out of sight from individuals nearby. In the grass between the shed and the fence where R7 squeezed through to enter House 1's backyard, there was a large pile of random wood near the corner of the fence.

On 9/18/19 at 4:03 PM, V2 stated R7 slipped through a fence on 9/15/19 and the staff informed her by text at 7:30 PM. V2 stated R7 had to have gotten out of the facility through the side door by the kitchen "because the alarm is not working." V2 stated the facility needed an entire new alarm system. V2 stated the alarm code did not work on the other side door, either, and and did not know why the chair was propped against the outside of the door.
Facility document, Elopement Risk Assessment Protocol, undated, shows, "Profile of an at risk resident: Diagnosis of dementia or related

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 19	S9999		

disorder resulting in confusion, disorientation ..., Verbalizes a strong desire to leave, return to another place, time ..., Typically exercises poor judgement ..., Maintains a high level of anger and frustration." The documents shows, "Wandering: The wandering individual may also seek exits, may be considered an elopement risk and may infringe upon the personal space of others."

Facility document, Wandering Persons, undated, shows, "[Facility] will provide a secure environment for residents at risk of wandering away from the House. Plan: The House shall implement supervision and intervention measures while insuring safety and quality of life for the residents. Best Practice: 1. All doors will be alarmed at all times .... 3. When doors are disarmed, they must be visually monitored to ensure that no residents leave the House unsupervised. 4. If a resident wants to go for a walk and walking is appropriate, the staff person should accompany the resident on the walk and attempt to redirect the resident back to the House. 5. The door ... can not be barred or obstructed in any way.

On 9/18/19 at 10:16 AM, V2 (Director of Nursing) stated the facility had no policy regarding how staff were to supervise residents while outdoors.

3. Facility census, dated 9/11/19, shows R7 and R12, reside in House 2.

R7 and R12's clinical record shows a history of elopement attempts.

On 9/16/19 at 10:18 AM in House 2, the exit door on the side of the house near the kitchen, and opening to the outdoor yard, was able to be opened with no alarm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 20	S9999		

On September 16, 2019 at 9:00 AM, V5 (Certified Nurse Aide) attempted to open the side rear door of the house. V5 entered the exit code on the keypad but was unable to unlock the door using the code. V5 attempted to push forcefully on the door and was not able to open the door. Through the door glass, a piece of wrought iron patio furniture was visible and blocking the door exit.

On 9/16/19 at 1:00 PM, an environmental tour of the facility was conducted with V14 (Director of Maintenance). During the tour, V14 demonstrated that two of the three exit doors in House 2 did not have functioning exit door locks or alarms. V14 stated without the operational coded key pads, the doors would remain unlocked and residents could freely exit the building without being noticed by facility staff and no alarm would sound. Patio furniture was located on the outside of one of the doors blocking the door. Multiple, unsuccessful attempts were made to push the exit door open. V14 walked outside, appeared at the door, removed an unknown object from the outside upper corner of the door, and the door opened.

On 9/19/19 at 1:50 PM, two woodenwedges were observed on the ground outside of the rear, side exit door of House 2. V14 stated the staff place the wooden wedges between the door frame and the door from the outside as a temporary solution to keep the door closed because there was no functioning lock or alarm on that door.

The facility's census dated September 11, 2019 shows R5, R6, R7, R10, R11, R23, R33, R34, R35, R36, R37, R38, and R39 reside in the house with the obstructed exit door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 21	S9999		

The facility's Alzheimer's Program Statement dated December 31, 2007 shows: "Magnetic locking doors control access to each house. A keypad by each door to the house allows staff easy access into or out of the house but helps to insure that residents do not elope from their "house."

The facility's undated Evacuation Plan shows three exit doors on the building map, including the rear side door of the building.

(A)

2 of 3 Licensure Violations

330.710a)
330.715a)
330.715b)
330.910a)
330.920a)f)
330.1310a)
330.1310b)2)
330.1310c)1)
330.1310g)
330.1310j)

Section 330.710 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part.

Section 330.715 Request for Resident Criminal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 22	S9999		

History Record Information

a) A facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)

b) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender.

Section 330.910 Personnel

a) A facility shall not employ an individual as a nurse aide or a person who performs these types of duties unless the facility has inquired of the Department as to information in the Registry concerning the individual. (Section 3-206.01 of the Act) The Department shall advise the inquirer if the individual is on the Registry, if the individual has findings of abuse, neglect or misappropriation of property in accordance with Sections 3-206.01 and 3-206.02 of the Act, and if the individual has a current background check. (See Section 330.911 of this Part.)

Section 330.920 Consultation Services

a) The facility shall designate a staff member to provide social services to residents. If the staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 23	S9999		

member designated to provide social services is not a social worker, the facility shall have an effective arrangement with a social worker to provide social service consultation.

f) Facilities that care for mentally retarded or discharged psychiatric residents shall be required to have a social worker who shall devote at least 40 hours per week providing that the facility cares for 75 or more residents. Facilities caring for less than 75 residents shall have a social worker who may be assigned other duties or shared with other facilities.

Section 330.1310 Activity Program
a) The facility shall provide an ongoing program of activities to meet the interests and preferences and the physical, mental and psychosocial well-being of each resident, in accordance with the resident's comprehensive assessment. The activities shall be coordinated with other services and programs to make use of both community and facility resources and to benefit the residents.
b) Activity personnel shall be provided to meet the needs of the residents and the program. Activity staff time each week shall total not less than 45 minutes multiplied by the number of residents in the facility. This time shall be spent in providing activity programming as well as planning and directing the program. The time spent in the performance of other duties not related to the activity program shall not be counted as part of the required activity staff time.
2) Activity personnel working under the direction of the activity director shall have a minimum of 10 hours of in-service training per calendar or employment year, directly related to recreation/activities. In-service training may be provided by qualified facility staff and/or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 24	S9999		

consultants, or may be obtained from college or university courses, seminars and/or workshops, educational offerings through professional organizations, similar educational offerings or any combination thereof.
c) Activity Director and Consultation
1) A trained staff person shall be designated as activity director and shall be responsible for planning and directing the activities program. This person shall be regularly scheduled to be on duty in the facility at least four days per week.
g) The facility shall provide a specific, planned program of individual (including self-initiated) and group activities that are aimed at improving, maintaining, or minimizing decline in the resident's functional status, and at promoting well-being. The program shall be designed in accordance with the individual resident's needs, based on past and present lifestyle, cultural/ethnic background, interests, capabilities, and tolerance. Activities shall be daily and shall reflect the schedules, choices, and rights of the residents (e.g., morning, afternoon, evenings and weekends). The residents shall be given opportunities to contribute to planning, preparing, conducting, concluding and evaluating the activity program.
j) Residents' participation in and response to the activity program shall be documented at least quarterly and included in the clinical record. The facility shall maintain current records of resident participation in the activity program.

This REQUIREMENT was not met as evidenced by:

#1. Based on interview and record review, the facility failed to follow the facility's guidelines for Illinois background checks for newly admitted residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 25	S9999		

This applies to 7 of 7 residents (R17, R24, R26, R27, R33, R35, and R44) reviewed for criminal background checks in the sample of 44.

The findings include:

On September 19, 2019 at 10:40 AM, V21 (Business Office Manager) said she had only been working at the facility for approximately one month and it was her responsibility to complete criminal background checks on newly admitted residents. V21 said she had received some orientation regarding doing background checks on residents, however, she did not know exactly what websites she should check. "I knew I had to check the sex offender website, but I didn't know what website to check for criminal background activity, so I was checking the current inmate website. All the residents came up as not being an inmate. That didn't seem right since I knew they weren't inmates now because they lived here, but I didn't know how else to do it."

The facility provided a list of residents admitted to the facility since April 1, 2019. The following information was obtained from the facility:

R17 was admitted to the facility on 5/22/2019. R17's sex offender status was not checked by the facility until 9/18/2019. The criminal background check for R17 was not initiated or completed as of 9/18/2019.

R24 was admitted to the facility on 5/31/2019. R24's sex offender status was not checked by the facility until 9/18/2019. The criminal background check was not initiated or completed as of 9/18/2019.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 26	S9999		

R26 was admitted to the facility on 8/23/2019. R26's sex offender status was not checked by the facility until 8/26/2019. R26's criminal background check was not initiated or completed as of 9/18/2019.

R27 was admitted to the facility on 9/13/2019. R27's sex offender status was not checked by the facility until 9/18/2019. The criminal background check was not initiated by the facility until 9/19/2019.

R33 was admitted to the facility on 9/11/2019. R33's sex offender status was not checked by the facility until 9/18/2019. R33's criminal background check was not initiated by the facility until 9/19/2019.

R35 was admitted to the facility on 8/29/2019. R35's criminal background check was not initiated or completed as of 9/18/2019.

R44 was admitted to the facility on 7/19/2019. R44's sex offender status was not checked by the facility until 9/18/2019. R44's criminal background check was not initiated or completed as of 9/18/2019.

V21 provided the facility's Illinois Background Checks Guidelines, dated February 1, 2018. V21 said, "I just received these guidelines today." The guidelines show: "Guidelines: For all new admissions, it is required that sex offender and criminal background checks are run. It is the responsibility of the Director of Admissions to ensure that these checks are run and to complete any follow up required. Upon completion, all offender checks should be uploaded to [electronic medical record] and attached to the guest's financial folder. Sex offender background checks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 27	S9999		

are to be run by the following links below prior to accepting the guest. Both state and national registries should be checked. If the sex offender checks indicate a clean record, the guest can be accepted based on the sex offender checks. A criminal background check should be run using the following link to the Illinois Department of Corrections website prior to accepting the guest. For all guests that admit to [the facility], it is required that a paid criminal background check request be submitted within 24 hours of admission utilizing the CHIRP (Criminal History Information Response Process) system, which can be accessed at the following link."

#2. Based on interview and record review, the facility failed to follow their policy for employee background checks prior to employment.

This has the potential to affect all 39 residents residing in the facility.

The findings include:

The facility's Resident Census and Condition of Residents form, dated September 16, 2019 shows the facility census as 39 residents.

The facility's September 1 through 16, 2019 staffing schedule shows V23 (Caregiver) was scheduled to work in all three resident houses at the facility during the scheduled period.

On September 18, 2019, eight random employee files were reviewed for facility background checks prior to the employees being hired. Eligibility status for the eight employees was verified via telephone interview with V22 (Illinois Department of Public Health Registry Office Coordinator).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 28	S9999		

Facility documentation shows V23 (Caregiver) was hired by the facility in December 2018. As of September 18, 2019, the facility does not have any documentation to show V23 is eligible to work per the Illinois Health Care Worker Registry. On September 18, 2019 at 9:45 AM, V22 said, V23 needs to be fingerprinted. "The registry does not show [V23] as an employee at the facility. When I click on his training and work history, they don't have him as working at the facility, so they need to update his work history. They can employ him up to 90 days pending the fingerprint outcome. It's called a conditional hire. They have 30 days to enter his work history from his date of hire. [V23] does not show eligible to work at this time and should not be working at the facility."

The facility's undated Background Checks Policy shows: "All offers of employment at [the facility] are contingent upon clear results of a thorough background check. Background checks will be conducted on all final candidates and on all employees, who are promoted, as deemed necessary." The facility's Background Check Policy does not show employees should be verified on the Illinois Health Care Worker Registry.

#3. Based on observation, interview and record review, the facility failed to provide meaningful, engaging activities to residents, failed to document resident activity participation, failed to provide a minimum of ten hours of activities training to resident specialists/caregivers and failed to employ an activity director for greater than two months.

This applies to all 39 residents residing in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 29	S9999		

The findings include:

A) Resident Census and Condition of Residents, dated 9/16/19, shows 39 residents were residing in the facility at the time of the survey.

The activity calendar showed the following: 9/16/19 = 10 AM - Exercise, 10:30 AM - Art Projects, 2 PM -Activity Baskets, 3 PM - Games (House 2, House 3), 3 PM Bingo - (House 1), 6 PM Movies.

The census sheet showed that there were 14 residents living in House 1. On 9/16/19 at 10:00 AM to 10:30 AM, there were only 6 residents (R19, R22, R26, R29, R30 & R32) throwing a foam ball and using bats to hit the ball as form of exercise in the dining room at that time as indicated in the activity calendar. The rest of the residents were either sleeping in front of the television in the living room. There was no activity going on at 10:30 AM.

On 9/16/19 at 9:00 AM, R5 was sitting in a reclining wheelchair asleep in front of the television. At 11:45 AM, R5 remained in his reclining wheel chair facing the television and sleeping. R5 was not engaged in any activity the entire morning. At 11:45 AM, R11 and R37 were sitting at the dining table asleep in their wheel chairs as a staff was at the table performing a coloring activity with two other residents.
The census sheet showed that there were 13 residents living in House 2. On 9/18/19 at 2:30 PM, during Activity Baskets (Arts and Crafts) there were only 4 residents (R10, R11, R33 & R38) actively participating while 3 residents either sleeping or were not engaged. At 2:40 PM in House 1, there were only 4 residents (R8, R28, R30 & R32), waiting for the activity to start in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 30	S9999		

dining area. There were 2 residents (R25 & R31) who were not participating while the rest of the residents were in their respective rooms. At 2:50 PM in House 3, no activity was going on. There were 6 residents (R4, R14, R15, R16, R18 & R41) sleeping in front of the television, 2 residents (R13 & an unidentified newly admitted resident) were smoking on the patio. The rest of the residents were in their respective rooms. On 9/16/19 at 11:45 AM, R7 was sitting in the dining room playing with bingo chips. R7 was stacking the chips but not able to play the game and was not engaged in the activity.

On 9/18/19 at 10:30 AM, V3 (Activities Director) stated she tries to provide activities for the different resident skill levels. She provides training to the staff continuously to reinforce to staff to follow the activity calendars. She sets up activities for resident in a house, gets the staff started on providing the activity, and then moves on to another facility house to start another activity. The staff do need training on how to abort an activity if the residents are not engaged. V3 stated neither she or the Resident Specialists/Caregivers, document resident activity attendance in the resident clinical records.

On 9/18/19 at 12:00 PM, V2 (Director of Nursing) provided all Resident Specialist/Caregiver training documentations. Review of the trainings show no Resident Specialists/Caregivers were provided training on performing activities to residents.

Facility document Activity Director, undated, shows the facility had no Activity Director employed between 11/27/18 and 2/12/19.

Record review showed no documentation of resident activity attendance at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 31	S9999		

#4. Based on interview and record review the facility failed to provide staff that are designated to provide social services and failed to provide social service consultation and provide services to residents with mental health needs.

This applies to all 39 residents residing in the facility.

Resident Census and Condition of Residents, dated 9/16/19, shows 39 residents were residing in the facility at the time of the survey.

On 9/19/19 at 11:40 AM, V2 (Director of Nursing) stated the facility had had no social worker employed at the facility either as a consultant or full/part time employee. V2 was unable to provide any social worker consultation reports.

Face sheet, undated, shows R24 was admitted on 5/31/19 to the facility from a local acute care psychiatric hospital. Neuropsychological Evaluation, dated 5/24/19, shows R24 was a resident of the prior long-term care facility for approximately three months when he became verbally abusive toward his roommate and threatened to harm him by strangulation. R24 has a history of exhibiting paranoia and threatened to call 911 with report that everyone was against him. The previous long-term care facility indicated R24 was unpredictable and dangerous to himself and others. The evaluation shows R24 had a previous psychiatric hospitalization for similar behaviors a few weeks prior to the most recent hospitalization. The evaluation also showed R24 did not have dementia.

Functional Assessment, dated 5/24/19, shows

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 32	S9999		

R24 had "Frequent outbursts or behaviors presented."

Resident risk assessment, dated 5/31/19, shows R24 had uncontrollable anger and was difficult to redirect or became combative with family/staff.

Nursing notes, dated 6/3/19, show R24 was paranoid and stated staff were stealing his belongings.

Nursing notes, dated 9/6/19, show R24 left the facility AMA (Against Medial Advice), without psychotropic medications.

Review of R24's clinical record showed no social services documentation for R24.

(C)

3 of 3 Licensure Violations

330.710a)
330.720b)
330.1120a)
330.1145a)
330.1145d)
330.1520a)
330.1520b)
330.3720b)7)
330.4210a)
330.4240a)

Section 330.710 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 33	S9999		

administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part.

Section 330.720 Admission and Discharge Policies

b) No resident determined by professional evaluation to be in need of nursing care shall be admitted to or kept in a sheltered care facility. Neither shall any such resident be kept in a distinct part designated and classified for sheltered care.
Section 330.1120 Personal Care

a) Each resident shall have proper daily personal attention and care including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician.

Section 330.1145 Restraints

a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of movement and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 34	S9999		

should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part.

d) Physical restraints shall not be used on a resident for the purposes of discipline or convenience.

Section 330.1520 Administration of Medication

a) All medications taken by resident/s shall be self-administered, unless administered by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents.

b) No person shall be admitted to a facility who is not capable of taking his or her own medications and any needed biologicals, as approved in writing by the resident's personal physician. Facility staff may remind residents when to take medications and watch to ensure that they follow the directions on the container.

Section 330.3720 Plumbing and Heating

b) All plumbing installations and fixtures on the premises shall be of such a type and design that danger of contaminated water entering the drinking water piping by backflow or back siphonage is eliminated. The following standards shall be used as a guide to determine satisfactory compliance of individual fixtures:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 35	S9999		

7) Hot water distribution systems shall be arranged to provide hot water of at least 100 degrees Fahrenheit at each hot water outlet at all times;

Section 330.4210 General

a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by law based on their status as a resident of a facility. (Section 2-101 of the Act)

Section 330.4240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

This Regulations were not met as evidenced by:

#1. Based on observation, interview and record review the facility failed to assess, obtain a physician's order and care plan 1 resident's (R3) physical restraint. This applies to 1 resident (R3) out 39 residents reviewed for restraints.

Findings include:

R3 is a 63-year-old resident with a diagnosis of Dementia, cognitive decline and Diabetes. R3 is totally dependent on direct care staff for all activities of daily living. R3 has numerous behaviors including biting her arms. R3 was observed on September 16, 2019 from 11:10AM to 12:10PM with socks on her hands and arms in seated in an adult geriatric chair. R3 was observed to make numerous attempts to bite her arms. R3 did not respond to any redirection provided by V10 (Resident Specialist/Care Giver

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 36	S9999		

Supervisor). R3 was also observed on September 17, 2019 from 8:00AM to 11:35AM with socks on her hands and attempting numerous times to bite her arms.

R3's room was observed at 10:35AM with V16 (Resident Specialist/Care Giver). R3's bed was positioned directly against the wall with a partial side rail and matt/pad on the floor. V16 stated that the side rail and bed position was used to keep R3 in bed.

V2 (Director of Nursing) stated on September 17, 2019 that R3's side rail was used because R3 has seizures and for safety.

A review of R3's medical record indicates that there was no service plan or physician order for the use of the side rail as restraint. In addition, there was no assessment, service plan or physician order for the use of the socks to prevent R3 from biting herself.

Facility's policy undated on use of side rails documents: "The use of siderails is prohibited unless they are deemed necessary to treat a resident's medical condition." "Should a medical symptom warrant the use of siderail (s) this will be reflected by Physician's Orders for use of.

#2. Based on observation, interview and record review, the facility failed to ensure that residents were able to take their own medications.

This applies to all residents in the facility.

The findings include:

The facility census showed that there were 39 residents in the facility. There were 3 separate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 37	S9999		

buildings identified as House 1, House 2 and House 3.

During medication pass on 9/16/19 at 12:15 PM, V9 (Licensed Practical Nurse) crushed R17's medications and mixed in the apple sauce prior to medication administration. V9 said that R17 needed his medications crushed so he can swallow easily.

On 9/18/19 at 2:30 PM, V11 (Licensed Practical Nurse) said that none of the residents were able to take their own medications independently. V11 stated that of the 39 residents, 21 residents (R3, R4, R5, R8, R9, R10, R11, R14, R15, R16, R17, R23, R28, R30, R34, R35, R36, R37, R38, R41 and R42) identified as requiring medications to be crushed. V11 also said that 5 residents (R27, R28, R30, R34 and R35) needed parenteral medications and unable to administer their own injections.

The undated facility policy titled, "Policy on Administration of Medication," required, "All medications taken by residents shall be self-administered, unless administered by personnel who are licensed to administer medications ... Facility staff may remind residents when to take medications and watch to ensure that they follow the directions on the container."

#3. Based on observation, interview, and record review, the facility failed to ensure the hot water heating system was in working order to supply hot water to residents. The facility also failed to assure temperatures of water were safe for resident's showers. The facility also failed to maintain resident dignity to residents while giving them showers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 38	S9999		

This applies to 13 of 40 residents (R5, R6, R7, R10, R11, R23, R33, R34, R35, R36, R37, R38, R39) observed during the environmental tour in the sample of 44.

The findings include:

On September 16, 2019 at 1:30 PM, V14 showed two hot water heaters located in the basement of House 2. Water was puddled under the hot water heater. V14 said the leaking hot water heater is a water heater designated for hot water to supply resident rooms and the shower room and had been leaking for approximately a month. V14 said the leaking hot water heater drips on the pilot light of the hot water heater, causing the pilot light to be extinguished, and disabling the heating device. V14 said, "I come down here about every four hours and relight the pilot light to get the water hot again. It takes about 45 minutes for the water to heat back up. The hot water heater holds approximately 100 gallons of water and is used for resident showers and in the resident rooms. I try to keep the water temperature at approximately 100 degrees to 110 degrees Fahrenheit. The other hot water heater is designated for the kitchen and the laundry room only, and is set at a higher temperature, which is 145 degrees Fahrenheit."

The facility's Water Temperature Monitoring sheets for August 2019 and September 2019 show the following water temperatures:

August 16, 2019: 68 degrees Fahrenheit (resident room)
September 3, 2019: 71 degrees Fahrenheit (shower room)
September 4, 2019: 75 degrees Fahrenheit (shower room)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING: _____ B. WING _____	10/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 39	S9999		

September 5, 2019: 73 degrees Fahrenheit (shower room)
September 6, 2019: 75 degrees Fahrenheit (shower room)
September 11, 2019: 75 degrees Fahrenheit (shower room)
September 13, 2019: 79 degrees Fahrenheit (shower room)

The facility's census dated September 11, 2019 shows R5, R6, R7, R10, R11, R23, R33, R34, R35, R36, R37, R38, and R39 reside in the house with the leaking water heater.
On September 19, 2019 at 1:17 PM, V13 (CNA-Certified Nursing Assistant) said, I am a floater CNA, so I go from house to house. I spend most of my time in House 2. The side doors don't lock in House 2. I told [V10] (CNA Supervisor) about three months ago. We have a lot of wanderers in that house. Also, the hot water has not been working in House 2 for about a month. Last week we did showers, and me and [V20] (CNA) brought water in buckets from the kitchen and then poured the buckets of water over the residents while the residents sat on a shower chair. The water was too cold in the showers. We did not have a thermometer to test the water to see if the water was too hot from the kitchen. We just felt the water with our hand and if the water was too hot we added cold water from the shower to the bucket."

The facility's Hot Water Policy dated September 16, 2019 shows: "Hot water temperature of at least 100 degrees at each water outlet at all times. Hot water available to residents at shower, bathing and handwashing facilities shall not exceed 110 degrees Fahrenheit."

(B)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

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