STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001663	A. BUILDING: _____ B. WING _____	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HEALTH CARE CENTER	1450 26TH STREET HIGHLAND, IL 62249

(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 Annual Licensure and Certification Survey Complaint #2147725/IL139354: Complaint #2147975/IL139672:	S 000		
S9999	Final Observations Annual Licensure and Certification Survey Complaint #2147725/IL139354: Complaint #2147975/IL139672: STATEMENT OF LICENSURE VIOLATIONS: 1/3 300.1210d)2)5) Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These Regulations were not met as evidenced	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 by: Based on observation, interview and record review, the facility failed to assess, monitor, and treat wounds per physician's orders for one of one residents (R17) reviewed for wounds in the sample of 49. Findings include: R17's Admission Record, print date of 10/27/21, documents R17 was admitted on 6/6/2019 with diagnosis of Type 2 Diabetes and Hypertension. On 10/25/21 at 12:45 PM, R17 was sitting in high back wheelchair. The wheelchair has a foot board on it. R17's left foot was on the foot pedal. R17's right foot toes had necrotic areas and R17's foot was on the ground. R17 was not wearing heel protectors at this time. R17 has multiple scabbed/ necrotic areas present on her left and right toes. At this time, V8, Certified Nurse's Aide (CAN), stated that she did not know what happen to R17's toes. On 10/26/21 at 9:03 AM, R17 was in her wheelchair sleeping. R17's left toes were swollen and red with necrotic areas noted on the 1st, 3rd, 4th and 5th toes. R17 was not wearing heel protectors. On 10/26/21 at 02:02 PM, R17 was sitting up in her high back wheelchair with no heel protectors on. R17's MDS, dated 8/3/21, documents R17 is severely cognitively impaired. R17's Wound Note, dated 10/12/20, documents, "At the request of the referring provider. (V32,	S9999		

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S9999	Continued From page 2 Physician), a thorough wound care assessment and evaluation was performed today. She has a wound of the left, fifth toe for at least 4 days duration. There is light serous exudate. There is no indication of pain associated with this condition." R17's Wound Note, dated 3/18/21, documents, "Impaired skin integrity noted to L (left) 3rd, 4th, 5th toes. MD (Medical Doctor) notified. Orders obtained and initiated. Son (V30) notified and aware." R17's Wound Note, dated 4/21/21, documents, "Area of skin integrity impairment noted to L (left) lateral 5th toe. Area blanchable and closed, possible diabetic vs ischemic etiology. MD notified. Orders obtained, (V17, Nurse Consultant) notified." R17's Nurses Note, dated 9/1/21, documents, "Spoke with (V30), POA (Power of Attorney). Updated on condition of left toes and doctor orders. Ok to proceed with vascular consult. Also updated on current visitation policy and will be coming to see mom." R17's Nurses Note, dated 9/5/21, documents, "Antibiotic therapy Clindamycin for left foot toes. No adverse side effects noted. No redness or swelling noted. Dark areas continue to the 3rd, 4th and 5th left toes. Area dry. No drainage or odor noted. Resident denies pain to foot." R17's Care Plan, dated 9/6/21, documents, "The resident has and arterial/ischemic ulcer of the left 3rd, 4th, 5th toes r/t (related to) Peripheral Arterial Disease, Uncontrolled Diabetes Mellitus with poor glycemic, Vascular insufficiency. Monitor/document wound: Size, Depth, Margins:	S9999		

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S9999	Continued From page 3	S9999		

periwound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated. Treatment as ordered."

R17's Nurses Note, dated 9/12/21, documents, "Resident continues on Clindamycin r/t (related to) toes on left foot. No adverse reactions to medication."

R17's Physician Orders documents, "Start date, 9/25/21 Cleanse left heel with wound cleanser, apply betadine BID (twice a day) and PRN (as needed). every shift. Start date 4/3/31, Betadine Solution (Povidone-Iodine) Apply to L 4th toe topically every shift for wound care Betadine BID. Apply to L lateral 5th toe topically every shift for wound care Betadine BID. Apply to L 5th toe topically every shift for wound care Betadine BID. Apply to L 3rd toe topically every shift for wound care Betadine BID. Start date of 4/21/21, Heel protectors every 6 hours for preventative check placement Q (every) 6 hours."

R17's Care Plan, dated 9/28/21, documents, "The resident has diabetic ulcer of the left heel r/t Diabetes, Vascular insufficiency. Monitor / document wound: Size, Depth, Margins: periwound skin, sinuses, undermining, exudates, edema, granulation, infection, necrosis, eschar, gangrene. Document progress in wound healing on an ongoing basis. Notify physician as indicated. Treatment as ordered."

R17's Nurse's Note, dated 10/19/21, documents, "MD office called. Patient does not have adequate blood flow to left leg/foot. Meaning wound will not heal to toes. MD setting up another test for next week, will fax paperwork."

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R17's Wound Assessment, signed 10/21/21, documents, R17 had a stasis wound on her left heel which was acquired on 9/17/21. The Wound Assessment documented that 100% necrotic tissue was present. The Wound Assessment documents the wound measured 1.5 centimeters (cm) length by 1.4 cm width by 0 cm.

On 10/26/21 at 3:15 PM, V31 Licensed Practical Nurse (LPN), stated that R17's toes are going to have surgery on 10/29/21. V31 further stated that she is not sure if it is both feet or just one and that she is unsure of what type of surgery R17 is going to have.

On 10/26/21 at 3:20 PM, V7 CNA, stated that she did not know what happened to R17's toes.

On 10/26/21 at 3:40 PM, V31 donned gloves and cleansed R17's multiple necrotic wounds on R17's 5 left toes using 2 different 2 x 2's. V31 then dried the wounds and applied Betadine to all the wounds using 2 different 2 x 2's. V31 then changed her gloves and cleansed the necrotic left heel wound and applied Betadine to the necrotic wound. V31 cleansed the necrotic areas on R17's right toe #1, in between #3 and #4 with normal saline and then applied Betadine to the areas. V31 then looked throughout R17's room for heel protectors. V31 stated, "I can't find any heel protectors in here, I will look in laundry."

There were no physician's orders for the treatment of R17's right toe wounds in her medical record.

On 10/27/21 at 2:30 PM, V2, Director of Nurses (DON) and V4 Assistant Director of Nurses

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(ADON), inspected R17's toes. At this time, V2 and V4, both stated that they were unaware of R17's right toe wounds. They both agreed that they looked necrotic. During inspection of the wounds, R17 stated that her right foot hurt. R17 was observed pulling her foot away from V2 and V4. R17's right foot had a necrotic area on toe #1, the side of toe #3 and #4 and at the base of toe #1. The area of the right foot where the toes meet is red and swollen from toe #3 to toe #5. The left foot has necrotic areas on toe#1 nail, the top of toe #2, the base of toe #3, the top of toe #4 and the tip of toe #5.

R17's Nurse's Note, dated 10/27/21, documents, "3 new areas noted. #1- RT (right) 1st toe. #2- Rt outer 4th toe. #3- Top of Rt foot below first toe. POA, (Power of Attorney) (V30) notified by phone. (V32) notified by phone and new orders received to apply betadine to areas twice daily. Wound assessments completed, (V23) wound are r/t (related to) vascular issues."

R17's Wound Assessment, signed 10/27/21, documents, "Observations / Data. 1. Location: right first toe 2. Indicate whether this site was acquired during residents stay or whether it was present on admission: Acquired. 2b. Date acquired: 10/27/21. 3a. Type: Statis." It continues, "5e. Necrotic tissue present (brown, black, leather, scab - like)." It continues, "5i. Describe the extent (%) of necrosis and / or slough in the wound bed: 100%. 6. Drainage. 6a. Type: none." It continues, "7. Odor. 7a. Odor present? No." It continues, "8. Wound Measurements. 8a. Length (cm) (centimeters). 0.3 8b. Width (cm) 0.3 8c. Depth (cm). 0.0 9. Peri-wound Tissue. 9a. Description of peri-wound tissue: Intact." It continues, "D. Evaluation. Wound Progress: First Observation, no reference. E. Pain. Mild 1-3."

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S9999	Continued From page 6 R17's Wound Assessment, signed 10/27/21, documents, "Observations / Data. 1. Location: right outer toe 2. Indicate whether this site was acquired during residents stay or whether it was present on admission: Acquired. 2b. Date acquired: 10/27/21. 3a. Type: Statis." It continues, "5e. Necrotic tissue present (brown, black, leather, scab - like)." It continues, "5i. Describe the extent (%) of necrosis and / or slough in the wound bed: 100%. 6. Drainage. 6a. Type: none." It continues, "7. Odor. 7a. Odor present? No." It continues, "8. Wound Measurements. 8a. Length (cm) (centimeters). 2.0 8b. Width (cm) 1.1 8c. Depth (cm). 0.0 9. Peri-wound Tissue. 9a. Description of peri-wound tissue: Intact." It continues, "D. Evaluation. Wound Progress: First Observation, no reference. E. Pain. Mild 1-3." R17's Wound Assessment, signed 10/27/21, documents, "Observations / Data. 1. Location: top of Rt (right) below 1st toe 2. Indicate whether this site was acquired during residents stay or whether it was present on admission: Acquired. 2b. Date acquired: 10/27/21. 3a. Type: Statis." It continues, "5e. Necrotic tissue present (brown, black, leather, scab - like)." It continues, "5i. Describe the extent (%) of necrosis and / or slough in the wound bed: 100%. 6. Drainage. 6a. Type: none." It continues, "7. Odor. 7a. Odor present? No." It continues, "8. Wound Measurements. 8a. Length (cm) (centimeters). 0.4 8b. Width (cm) 0.2 8c. Depth (cm). 0.0 9. Peri-wound Tissue. 9a. Description of peri-wound tissue: Intact." It continues, "D. Evaluation. Wound Progress: First Observation, no reference. E. Pain. Mild 1-3." On 10/27/21 at 3:00 PM, V2 stated that she should have been notified of R17's new wounds	S9999		

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S9999	Continued From page 7 and that the Doctor should have been notified for treatment orders. V2 further stated that R17 has had studies done to her left leg and she has really poor blood flow in that leg. On 10/27/21 at 4:00 PM, V1, Administrator, stated, "(R17) is having an angiogram on her left leg on Friday." On 11/2/21 at 9:00 AM, V2, stated that she has done some research and R17 has been seeing (V33 Wound Doctor) since 10/2020 for the wounds on R17's toes and has been seeing the foot doctor regularly. V2 stated, "(R17) should have heel protectors on at all times." On 11/2/21 at 2:30 PM, V32, Physician, stated, "(R17's) toes are bad, she now has good blood flow and warm feet since the surgery. I was aware of her right foot. I have been watching her feet but there was nothing else I could do that is why I sent her to vascular. Her problem was beyond my scope. Vascular took care of both legs not just the left leg." The facility policy and procedure Pressure Ulcer / Injury Risk Assessment, dated 7/2017, documents, "Steps in the procedure: c: If a new skin alteration in noted, initiate a (pressure or nonpressure) form related to the type of alteration in skin." It continues, "Documentation: The following information should be recorded in the resident's medical record utilizing facility forms: 1. The type of assessment(s) conducted." It continues, "4. Any change in the resident's condition, if identified. 5. The condition of the resident's skin (i.e. (for example) the size and location of any red or tender areas), if newly identified." It continues, "11. Initiation of a (pressure or non-pressure) form related to the	S9999		

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S9999	Continued From page 8 type of alteration in skin if new skin alteration noted. 12. Documentation in medical record addressing MD (Medical Doctor) notification if new skin alteration noted with change of plan of care, if indicated. 13. Documentation in medical record addressing family, guardian or resident notification if new skin alteration noted with change of plan of care, if indicated. Reporting: 1. Notify the supervisor if the resident refuses the procedure. 2. Report other information in accordance with facility policy and professional standards of practice. 3. Notify attending MD if new skin alteration noted. 4. Notify family, guardian or resident update if new skin alteration noted." (NO VIOLATION) 2/3 300.610c)4) 300.1210d)6) 300.1220b)3) Section 300.610 Resident Care Policies c)The written policies shall include, at a minimum the following provisions: 4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: Section 300.1210 General Requirements for Nursing and Personal Care d)Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,	S9999		

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S9999	Continued From page 9 seven-day-a-week basis: 6)All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b)The DON shall supervise and oversee the nursing services of the facility, including 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These Regulations were not met as evidenced by: Based on observation, interview and record review the facility failed to perform safe transfers, and conduct root cause analysis of accidents and implement progressive itnerventions to prevent falls and injuries for 4 of 6 (R6, R17, R18 and R41) residents reviewed for accidents and incidents. This failure resulted in R18 sustaining multiple skin tears, the largest measuring 9.5 centimeters by (x) 7 cm x 0 cm on her left arm.	S9999		

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S9999	Continued From page 10 Findings include: 1. R18's Face Sheet, printed on 10/26/21, documents R18 has diagnoses of Dementia without Behavioral Disturbances and Anxiety Disorder. R18's Incident Report, dated 6/4/2021 2:45 PM, documents "2 s/t's (skin tears) observed to LLE (left lower extremity) on 6/4/20 @ (at) this time. This nurse assisted with getting resident up this AM and s/t were not on LLE @ that time. No active bleeding noted to s/t's on LLE. One s/t noted to be 3 cm (centimeters) x (by) 3cm v-shaped. Second s/t noted to be 1 x 1cm V-shaped s/t. Res (resident) does propel herself independently in w/c (wheelchair) when up. Res frequently resistive to care and can be combative with staff @ times." It also documents R18 is oriented to person. The Report documents R18 is confused, impaired memory, and other as predisposing factors. The incident investigation does not identify how R18 sustained the skin tears and interventions put into place to prevent future injuries. R18's Care Plan, initiated on 6/16/21, documents that R18 had a skin tear. The Care Plan documented the following interventions with initiation date of 6/16/21: Encourage good nutrition and hydration in order to promote healthier skin; Identify potential causative factors and eliminate/resolve when possible; If skin tears occurs, treat per facility protocol and notify MD, family; Inform/instruct staff of causative factors and measure to prevent skin tears; Keep skin clean and dry. Use lotion on dry scaly skin; Monitor/document location, size and treatment of skin tear. Report abnormalities failure to heal,	S9999		

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S9999	Continued From page 11 signs and symptoms of infection, maceration etc. to MD; and treatment as ordered. R18's Incident Report, dated 8/19/2021, documents "Nursing Description: CNA (certified nurse's assistant) informed the nurse that the resident accidentally hit her RLE (right lower extremity) to the bed rail when she was trying to lay down. Resident did not c/o (complain of) pain during assessment. Skin tear to RLE 2 cm (centimeters) x 0 cm x 0 cm. was able to approximate the skin tear, cleansed it c (with) wound cleanser, applied TAO (triple antibiotic ointment) et (and) steri strips." The Report documents "Resident Description: no idea what happened." The Report did not document potential causative factors and or interventions to prevent R18 from future injuries/skin tears. R18's Care Plan Focus, dated 8/20/21, documented R18 sustained a skin tear to her right lower leg. There were no progressive interventions added to the Care Plan at that time to prevent R18 from future injuries/skin tears. R18's General Note, dated 9/8/2021 at 2:51 PM, documents "Note Text: Skin tear noted to left shin. New treatment orders received. V32, Physician and V36, Power of Attorney, aware." R18's Care Plan Focus, dated 9/9/21, documented R18 sustained a skin tear to her lift shin. There were no progressive interventions added to the Care plan at that time to prevent R18 from future injuries/skin tears. On 10/27 and 10/28/21, the surveyor requested documentation of how R18 sustained the skin tear on 9/8/21. The facility did not provide any documentation regarding R18's skin tear.	S9999		

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S9999	Continued From page 12 R18's Incident Report, dated 9/17/2021 at 10:10 AM, documents "CNA's gave resident a shower. After shower resident crossed her legs resulting in a skin tear to anterior RLE." R18's Care Plan Focus, dated 9/17/21 documented R18 sustained a skin tear to her right shin. R18's Care Plan Interventions, dated 9/17/21, documents "Shin guards to BLE (bilateral lower extremities) at all times. R18's Nursing Note, dated 9/20/2021 at 7:26 AM, documents "Note Text: Root Cause: Resident's skin is very thin and fragile. Intervention: Immediate first aide performed. Treatment initiated. Shin guards to be worn at all times." R18's Care Plan Interventions, dated 9/20/21 document the following: Staff education on transfers, good skin care; and Towel around legs during showers. R18's Incident Report, dated 9/24/2021 at 7:34 AM, documents "Nurse was called in the resident's room during early morning bed check. resident was laying on her lt (left) side facing the wall. she was holding her lt (left) arm covered with her night gown. blood noted et (and) skin tear was located to the lower anterior arm. able to approximate the skin tear 9.5 cm x 7 cm x 0 cm. cleanse with wound cleanser, applied steri strips et xeroform, covered with kerlix. informed MD et left VM (voice mail) to daughter call the facility back." The Report did not document how R18 sustained the skin tear or what interventions were implemented to prevent R18 from future injuries. R18's Care Plan Focus, dated 9/24/21, documented R18 sustained a skin tear to her	S9999		

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right upper arm. There were no progressive interventions added to the Care plan at that time to prevent R18 from future injuries/skin tears.

R18's Incident Report, dated 10/14/2021 at 11:25 AM, documents "Nursing Description: resident was laying on her bed when nurse was getting ready to get her tx done for the day et found a couple skin tear to her left upper arm. it looks like she obtained it over 24 hrs. ago. #1: 1.5 cm x1 cm x 0 cm #2: 3 cm x 3 cm x 0 cm. soak the skin with the wound cleanser et was able to approximate the skin tear. applied steri strips et xeroform et cover it with dry gauge" It also documents "Resident Description: States she rubbed her arm on her cup on accident and tore her skin slightly." The Report did not document progressive interventions to prevent her from future skin tears.

R18's Care Plan, revision date 10/15/2021, documents "The resident has a Skin Tear L (left) forearm, 8/20/21 Right lower leg. 9/9/2021 Skin tear to left shin. 9/17/2021 Skin tear to right shin. 9/24/2021 Skin tear to right upper arm. 10/14/2021 skin tear to left upper. Interventions 9/17/2021 shin guards to BLE (bilateral lower extremities) at all times. 10/15/2021 Geri sleeves at all times.

On 10/25/2021 at 11:30 AM R18 was sitting in the wheelchair in the dining room with a short sleeve shirt on and pants. R18's her upper chest, arms were exposed. There was a dressing to R18's left lower arm, left upper arm and right arm.

On 10/25/21, at 2:20 PM R18 was assisted to the toilet and observed a dressing to both legs. R18 was not wearing geri sleeves or shin guards.

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S9999	Continued From page 14 On 10/25/2021 at 2:23 PM, V5, Certified Nurse's Assistant (CNA), stated that he is not sure how the skin tears happened and is not aware of her interventions. V5 stated that he has not put on geri sleeves on shin guards on R18. V5 stated that R18 has thin and fragile skin. V5 stated that he is not aware of a shin guard that R18 is supposed to wear. On 10/26/2021 at 11:30 AM V2, Director of Nurse's stated that she was aware of the skin tears. V2 stated that she removed the bedrail from R18's bed. V2 stated that the geri sleeves and shin guard was the intervention put in place to prevent further skin tears but had not been put in place. V2 stated that they had been ordered but had not came in yet. V2 stated that she would prefer for R18 to wear long sleeves. V2 stated that there were no other interventions put in place while waiting for these items to come in. On 10/26/2021 at 2:50 PM V16, CNA, stated that R18 has multiple skin tears. V16 stated that R18 has fragile skin and the slight bump will cause her skin to tear. V16 stated that R18 does not have any interventions put in place to prevent more skin tears. V16 stated that she has requested the padding of R18's wheelchair and bed. V16 stated that R18 moves her own wheelchair at times. V16 stated that R18 doesn't have foot pedals and the metal prongs stick out next to R18's legs. V16 stated that she has not seen any shin guards and have not put them on her. V16 stated that they have put geri sleeves on R18 and she would remove them. V16 stated that no other interventions were put in place. V16 stated that R18 usually wears short sleeves. V16 stated that R18 should have something in place but at this time she doesn't. V16 stated that R18 needs something or the skin tears will continue to	S9999		

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S9999	Continued From page 15 happen. On 11/2/2021 at 2:30 PM, V32, Physician, state that he was notified of R18's skin tears. V32 stated that R18 is an older lady that is thin and frail. V32 stated that due to this her skin is fragile and easily injured. V32 stated that expects the staff to investigate and document incidents and accidents. V32 stated that he would expect the facility to put interventions in place and apply them to prevent reoccurring injuries to this resident. 2. R6's Admission Record, print date of 10/28/21, documents R6 was admitted on 5/27/20 with diagnoses of Chronic Pulmonary Obstructive Disease and Morbid Obesity. R6's MDS, dated 10/19/21, documents R6 is cognitively intact and requires extensive assist of 2 staff members for transfers. On 10/25/21 at 9:55 AM, V25 CNA and V26 CNA entered R6's room to do a mechanical lift transfer for R6 from the wheelchair to the bed. V25 operated the lift and pushed the mechanical lift to the bed while V26 CNA stood on the other side of the bed. V26 at no time held onto the mechanical sling while transferring R6 to bed. On 11/1/21 at 11:00 AM, V2 stated that she expects 2 staff to be present for a mechanical lift transfer and that the second person should hold onto the sling during the transfer. 3. R17's Admission Record, print date of 10/27/21, documents that R17 was admitted on 10/19/2019 with diagnoses of History of Falling, Anxiety, Insomnia and Difficulty in Walking.	S9999		

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R17's MDS, dated 8/3/21, documents that R17 is severely cognitively impaired, requires extensive assistance of 2 staff members for bed mobility, is totally dependent on 2 staff members for transfers, the activity of walking did not occur and during a surface to surface transfer R17 is not steady and is only able to stabilize with staff.

On 10/26/21 at 3:20 PM, R17 was lying in bed on her right side. R17's wheelchair was parked on the floor mat right beside R17's bed.

R17's Nurses Notes, dated 3/18/21, documents, "This nurse called to room due to resident being found in the floor next to her bed. Resident noted to be left side lying with head between nightstand and bed. Resident assessed and rolled to her back for transfer back to bed via (mechanical) lift. Transferred to bed without incident x 3 staff. Increased pain noted with PROM to left leg. Laceration 1 cm (centimeter) x 0.03 cm to right scalp above ear. 1 cm X 1 cm circular abrasion to area on scalp above left ear. Red area to forehead 11 cm x 4 cm top of left 4th toe 1.5 cm X 0.5 cm abrasion top of left 5th toe 4 mm (millimeter) X 3 mm abrasion."

R17's Incident Description, dated 3/18/21, documents, "Notes: Resident observed on the floor between her bed and night stand next to her window. Resident unable to state what had happened. root cause: poor safety awareness. intervention: floor mat by bed."

R17's Nursing Note, dated 8/29/21, documents, "Roommate reported fall to staff. (R17) tried to climb out of bed. Sitting on knees next to bed, holding grab bar on bed-so she was sitting upright. Did not hit appear to hit head. No injuries

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noted anywhere. Has a skin/fungal rash on abdomen, back, groin, buttocks-applied Triamcinolone cream & antifungal as ordered. Has areas on toes- treatment with betadine. All extremities with normal range of motion. Denies pain. She had been up for breakfast & lunch & down in bed between meals. She was wide awake. She said she tried to get up and was sitting on knees upright next to bed, holding grab bar on bed. Her normal orientation is confused. She is unaware of her physical limitations. Poor safety awareness. Total dependent 2 assist with transfers, toileting, dressing, bed mobility."

R17's Fall Report, dated 8/29/21, documents, "Notes, dated 8/31/21, Resident observed on the floor next to her bed on her knees. stated she tried to get up. No injury noted. root cause: poor safety awareness, attempting to stand without assistance. intervention pad alarm in bed."

R17's Incident Description, dated 9/11/21, documents, "This nurse called to room by (R17's) roommate. Advised that (R17) had fallen out of bed. She was sitting on side of bed facing toward her roommates' side of room. She was holding on to side rail of bed. She denied having pain or discomfort. Resident Description: Resident stated she did not know how she fell out of bed or what she was doing when she fell. "Predisposing Physiological Factors: Incontinent, Impaired Memory. Predisposing Situation Factors: Side Rails."

R17's Incident Follow up Note, dated 9/12/21, documents, Root Cause Analysis: pain response. Interventions: give HS (hour of Sleep) meds (medication) as soon as resident gets laid down, and position resident closer to wall side of bed to reduce the risk of a roll out."

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R17's Nursing Note, dated 9/24/21, documents, "This nurse called to room by CNAs (Certified Nurse's Aides). Upon entering room this nurse noted res (resident) on floor next to bed on lt (left)side. Res noted to be incont (incontinent) of urine. non-skid socks in place. Bed noted to be in low position. No injuries noted. ROM (range of motion) wnls (within normal limits) for this res. no s/s (sign or symptom) of pain or distress noted. Res assisted back into bed with staff assti (assistance) of 2 with (mechanical) lift."

R17's Incident Report, dated 9/24/21, documents, "Predisposing Physiological Factors: Confused, Incontinent, Impaired Memory. Predisposing Situation Factors: Side Rails IP. Notes, dated 9/27/21, Root Cause: Resident was incontinent of urine. Intervention: 1 hour check and change while in bed."

R17's Care Plan, dated 6/10/19, documents, "At risk for falls and injuries r/t Medications: Psychotropic Meds/ Cardiovascular Meds. Medical Factor: CVA (stroke), Dementia and DM (Diabetes Mellitus". Date initiated 3/1/21: 1 hour checks for safety and assistance. Date initiated 9/27/21: 1 hour check and change while in bed."

On 11/3/21 at 12:05 PM, V2 stated that she agrees that R17 has fallen multiple times and no true root cause analysis has been done on some of the falls and that some of the fall investigations fail to document the time of the fall and when the resident was seen or assisted last. V2 stated that that type of information would be in the CNA charting.

The facility policy and procedure Transfers, dated 9/15/2019, documents, "Transfers. Policy: To

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promote safe transfer for the residents, as well as the staff, gait belts, (mechanical) lifts, and or sit to stand will be used, unless otherwise specified." It continues, "3. A minimum of two staff members is recommended when transferring with a (mechanical) lift. 4. When using a (mechanical) lift, pay close attention to be sure the (mechanical lift) sling is properly positioned. 5. When using a gait belt, apply the belt around the resident' s waist over clothing. Never apply gait belt over bare skin." It continues, "Follow Plan of Care to ensure the use of proper transfer technique."

The facility's policy and procedure Assessing Falls and Their Causes, dated 3/2018, documents, "Purpose: The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall." It continues, "Defining Details of Falls: 1. After an observed or probable fall, clarify the details of the fall, such as when the fall occurred and what the individual was trying to do at the time the fall occurred." It continues, "Identifying Causes of a Fall or Fall Risk: 1. Immediately after meeting safety and care needs, the nurse will determine the most likely case and implement a strategy to prevent further falls or reduce the possibility of injury and update care plan. 2. Within 24 hours of a fall=, begin to try an identify possible or likely causes of the incident. Refer to resident specific evidence including medical history, known functional impairments, etc. (et cetera). 3. Evaluate chain of events or circumstances preceding a recent fall, including: a. time of day of the fall; b. Time of last meal; c. What was the resident doing; d. Whether the resident was standing, walking, reaching, or transferring form one position to another; e. Whether the resident was among other persons or alone" It continues, "h. Whether there is a

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S9999	Continued From page 20 pattern of falls for this resident." It continues, "3. All interventions will be fully implemented, added to the care plan and monitored for efficacy." 4. R41's Admission Record Sheet, undated, documents R41was admitted on 9/15/21 and had diagnoses of fracture of neck of femur (9/22/21), dementia, restlessness and agitation. R41's MDS Dated 9/29/2021 documents; R41 is moderately cognitively impaired, needs extensive assistance of two staff persons for h bed mobility, transfers, and toilet use. R41's MDS documents her balance was not steady and only able to stabilize with staff assistance when moving from seated to standing position, moving on and off toilet and surface-to- surface transfers. R41's Incident Report Dated 9/16/2021 at 3:30PM documents "Nurse was called in the resident's room and was informed that she was found in someone else's room. Resident was found by a corporate nurse sitting on the floor next to a chair. Resident stated that she was just walking around to see what's going on. She tried to sit on the chair inside the room and lost her balance and ended up on the floor next to the chair. Room was dark at that time. Resident was A&O1-2 (alert and oriented times one-two). Recently admitted to the facility with the dx of UTI et (and) taking antibiotics for it." Also Documents R41 was confused,impaired memory and gait imbalance. R41's Care Plan Intervention, dated 9/16/21 documents R41 is at risk for falls and injuries related to history of falls, poor balance, unsteady gait, weakness and diagnosis of Alzheimer's. The Care Plan Intervention, dated 9/16/21 at 3:40 PM,	S9999		

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S9999	Continued From page 21 documents "Resident educated on asking for assistance with transfers." R41's Incident Report Dated 9/16/2021 at 6:30 PM document R41 was found sitting with legs straight out in middle of room. Resident states that she was feeling nauseous and pointed towards the trash can. Also documents R41 was confused, impaired memory and gait imbalance. R41's Care Plan Intervention, dated 9/16/21 at 6:30 PM documented "Rollator moved from side of bed and replaced with w/c (wheelchair). Resident encouraged to use w/c and staff will assist with any use with rollator." The Care Plan did not address if R41 needed increased supervision due to two falls in one day. R41's Incident Report Dated 9/16/2021 at 7:45 PM documents; "Nurse was called in the resident room by the night shift CNA. Resident was sitting on the floor in the middle of her room, facing her closet. her legs were laying straight out while sitting on rt side. She was very confused." Facial grimacing flushed and is touching her left hip like its bothering her bad. When this nurse and two CNAs got her up, she was not able to bear weight on the left leg/hip. She could not find the right word of how she's feeling. She was asked again if it hurt and she did not answer, she was asked if it's just spasms and she said no. She was placed on her wheelchair and all she did was moan and touching/ pushing on her left hip like it relieving something." R41's Care Plan, dated 9/16/21, at 7:45 PM documented, "low bed, scoop mattress." R41's Hospital Emergency to Admission Record; dated 9/16/2021, documents; CT (Computed	S9999		

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S9999	Continued From page 22 tomography) Results on 9/17/2021 findings, "Acute fracture across the femoral neck near the subcapital region. Cephalad displacement of the distal component by half a shaft. Anterior apex angulation." On 11/1/2021 at 9:45 AM, V2 stated that she would expect for the appropriate intervention to be put in place. (B) 3/3 300.1010h) 300.1210d)3) 300.1210b)4) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and	S9999		

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S9999	Continued From page 23 determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. These Regulations were not by as evidenced by: Based on record review, observation and interview, the facility failed to monitor, assess, and provide interventions to prevent significant weight loss for 1 of 11 residents (R18) reviewed for weight loss and nutrition in the sample of 49.. This failure resulted in R18 having a 26.5 pound	S9999		

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weight loss in 24 days.

Findings include:

R18's Care Plan, revision date 5/31/021, documents, "Altered nutrition and hydration risk r/t (related to) dx (diagnosis) Dementia, Depression, Hypertension, Infection/uti (urinary tract infection)." It also documents diagnosis of "pro/cal malnutrition."

R18's Admission Record, not dated, documents "Diagnosis Information Description: Moderate Protein-Calorie Malnutrition." Onset date 5/17/2021.

The resident's weight record indicated on 10/4/2021 a weight of 120.1 pounds (lbs) pounds and on 10/28/2021, a weight of 93.6 lbs, a 22% weight loss in 24 days.

R18's Documentation Survey Report Eating & Amount, dated October 2021, indicated the average intakes between were between 0-50 % overall. It also documents R18 refused 16 meals. 12 meals had no documentation of R18's intake. It also documented R18 consumed 0%-25% for 14 meals, 26%-50% for 17 meals, 51%-75% for 9 meals, and 76%-100% for 13 meals. No substitutes or alternates were documented.

On 10/25/2021 at 11:20 AM, R18 was sitting in the dining room at the table with food in front of R18. R18 had thin, frail appearance. R18 made no attempts to eat her food. At 11:25 AM, V16, Certified Nurses assistant (CNA), asked R18 if she wanted anything. R18 did not respond. At 11:27 AM, R18 was holding a dinner roll in her right hand. R18 made no attempts to eat her meal. At 11:39 AM, R18 was holding her dinner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001663	A. BUILDING: _____ B. WING _____	11/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HEALTH CARE CENTER	1450 26TH STREET HIGHLAND, IL 62249

(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		

roll in her left hand and her fork in her right hand. R18 was twirling her fork on the table. From 11:39 AM to 11:52 AM, R18 made no attempts to eat her meal. At 11:53 AM, V5, CNA, standing over R18, gave R18 a bite of meat and left the table. V5 returned to the table and picked up R18's spoon and attempted to give her another bite without success. V5 then left the table. At 12:08 PM, V5 returned to R18's table, standing over her, gave her a bite of corn and left the table. From 12:08 PM to 12:17 PM, R18 was sitting at the table, no attempts made to eat the meal. At 12:20 PM, V16 removed R18's tray from the table. V16 verified that R18 ate 0% of her meal. V16 offered R18 a bowl of soup and said she would return with it. At 1:21PM, R18 spilled her drink on the table and floor. At 2:20 PM, V5 removed R18 from the table. No soup was ever brought to the table. V5 and V16 did not sit, encourage, and assist R18 with eating her meal. V5 and V16 did not provide an alternate for the meal that she did not eat.

On 10/25/2021 at 1:30 PM, V16 stated that R18 needed assistance and encouragement with her meals. V16 stated that R18 needs someone to help her eat at times. V16 stated that sometimes R18 will feed herself and some days she will refuse. V16 stated that R18 has not been eating and that she has lost some weight. V16 stated that she is not sure if R18's weight loss is being addressed. V16 stated that R18 does not get any supplements.

On 11/1/2021 at 9:46 AM, V27, Registered Dietician, stated that she had seen R18 in August 2021 for a 5lb weight loss from May 17, 2021 to August 6, 2021. V27 stated that R18 was consuming 50% of her meals. V27 stated that at that time she did not make any recommendations

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S9999	Continued From page 26	S9999		

because R18 was already receiving supplements. V27 stated that R18 has had a significant weight loss. V27 stated that with R18 having a diagnosis of proteins malnutrition her intake should have been monitored closely and would have expected staff to encourage R18 to eat. V27 stated that she was not aware of R18's change in intake or her pressure ulcer. R18 stated that even with supplements the lack of consumption and encouragement caused the significant weight loss. V27 stated that R18's weight loss is concerning.

On 11/1/2021 at 10:59 AM, V2, Director of Nursing (DON), stated with R18 having a diagnosis of malnutrition with a previous weight loss, R18 intake should have been monitored closer and staff should have sat with her and encouraged intake.

On 11/2/2021 at 2:30 PM, V32, R18's Primary Physician, stated that R18 has dementia. V32 stated that R18 had a significant weight loss. V32 stated that with R18's disease process it is inevitable that dementia patients will transition into other stages of dementia and not eat. V32 stated that with R18's disease progression, he would have expected the staff to sit down, encourage, and assist R18 to eat her meal. V32 stated that he would expect the staff to be monitoring R18's intake and notify the dietician and himself of R18 not eating to get intervention put in place to prevent this significant weight loss. V32 stated that he was not notified of R18 change in meal intake prior to 10/26/2021.

The Facility's Condition Changes-Clinical Protocol, revised date March 2018, documents "3. Direct care staff, including nursing assistants will be trained in recognizing subtle but significant

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S9999	Continued From page 27 changes in the resident (for example, a decrease in food intake, increased agitation, changes in skin color or condition) and how to communicate these changes to the Nurse. 4. Nursing assistants are encouraged to use the Stop and Watch Early Warning Tool to communicate subtle changes in the resident to the nurse. " (B)	S9999		