STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015044	A. BUILDING: _____ B. WING _____	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHVIEW IN THE WOODLANDS	1000 FALCON POINT PLACE ROCKTON, IL 61072

(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 Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: Violation 1 of 3 330.770a) 330.770c) Section 330.770 Disaster Preparedness a) For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility. c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to: This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure fire drills were completed quarterly. This applies to all 16 residents who reside on the sheltered care unit at the facility. Findings include: The facility roster printed on 9/5/23 showed the facility census was 16 residents in the sheltered	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care unit. The facility's Fire Drill Report showed the last completed fire drill was conducted on 3/30/23. There were no Fire Drill Reports for the second quarter of the year (April, May, June). On 9/5/23 at 09:00 AM, V5 Maintenance Manager stated the second quarter fire drills were missed. The facility's undated Fire Drill Policy showed Fire drills shall be conducted on a bimonthly basis. (C) Violation 2 of 3 330.792a) 330.792b) Section 330.792 Testing for Legionella Bacteria a) A facility shall develop a policy for testing its water supply for Legionella bacteria. The policy shall include the frequency with which testing is conducted. The policy and the results of any tests and corrective actions taken shall be made available to the Department upon request. (Section 3-206.06 of the Act) b) The policy shall be based on the ASHRAE Guideline "Managing the Risk of Legionellosis Associated with Building Water Systems" and the Centers for Disease Control and Prevention's "Toolkit for Controlling Legionella in Common Sources of Exposure". This REQUIREMENT was not met as evidenced	S9999		

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S9999	Continued From page 2 by: Based on interview and record review the facility failed to develop a policy and procedure related to Legionella bacteria which applies to all residents in the facility. Findings include: The facility's Resident Roster printed on 9/5/23 showed the facility census was 16 residents. On 9/5/23 V1 Administrator stated the facility did not have a policy or procedure regarding Legionella bacterium. The facility did not/was unable to provide a policy/procedure at the time of the survey. (C) Violation 3 of 3 330.710a) 330.710c)3)F) 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. c) The written policies shall include, but are not limited to, the following provisions: 3) A policy to identify, assess, and	S9999		

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S9999	Continued From page 3 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: F) Development of 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. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure footrests were in place on a resident's wheelchair to prevent a resident from falling out of the wheelchair. This failure affects 1 of 3 residents (R101) reviewed for falls on the sample list of 5. Findings include: On 9/5/23 R101 was sitting in a high back wheelchair at the dining room table. R101 had a small, healed laceration to his mid-forehead near his hairline. R101's Admission Record printed on 9/5/23, shows diagnoses including dementia, depression, and hypertension. On 9/5/23 at 1:13 PM, V3, Licensed Practical Nurse (LPN), said R101 was in his wheelchair and the Certified Nursing Assistant (V4) was pushing him to the dining room. R101 planted his feet down which caused him to stop abruptly and he fell forward and hit his head on the floor. V3 said R101 sustained a two-centimeter (cm) laceration to his forehead. V3 said she got an order to put footrests on R101's wheelchair to	S9999		

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S9999	Continued From page 4 ensure they are always on his wheelchair, so it does not happen again. On 9/6/23 at 8:40 AM, V2, Director of Nursing (DON), said R101 was being pushed in his wheelchair when he suddenly put his feet down and he went forward and fell out of his wheelchair and hit his forehead. V2 said R101 no longer self-propels in his wheelchair, so he should have footrests on his wheelchair. R101's Care Plan dated 8/21/23 shows R101 is disoriented to person, place and time and has problems with judgement. R101's Care Plan dated 5/19/23, is in a wheelchair and is not able to propel himself on his own. R101's Nurse's Notes dated 8/31/23 at 10:00 AM shows CNA was pushing R 101 when he put his feet down on the floor and R101 fell out of the wheelchair, hit his head and sustained a 2 cm laceration. The nurse documented that she put leg rests on R101's wheelchair. (B)	S9999		