Illinois Department of Public Health

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 ______	C 06/22/2023

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 Complaint Investigation Survey 2315061/IL161107	S 000		
S9999	Final Observations Statement of Licensure Violations One of two violations: 330.710a) 330.4210b) 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 330.4210 General b) A resident shall be permitted to retain and use or wear his personal property in his immediate living quarters, unless deemed medically inappropriate by a physician and so documented in the resident's clinical record. (Section 2-103 of the Act) These Regulaiton were not met as evidenced by: Based on interview and record review, the facility failed to ensure a staff member did not sleep in a resident's bed for one of three residents (R3)	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

reviewed for personal property in the sample of three.

The findings include:

The facility's Employee Warning Notice for V3 CNA (Certified Nursing Assistant) dated 2/3/23 shows, "It was reported to me by the nurse on shelter care unit that she found [V3] sleeping in residents [R3] bed while resident was in common area. Also reported that she found him a 2nd time sleeping in [R3's] room while resident was wandering around in the room...[V3] will be on probation for 30 days if he is found sleeping again, additional disciplinary action will be taken including a suspension and or termination."

V8's RN (Registered Nurse) signed statement dated 2/3/23 shows, "To Whom it may concern: Events of night of 2/3/23 concerning [V3]. [V3] found by writer sleeping in [R3's] room on top of bed-R3 in common area. Found [V3] again in [R3's] room on bed asleep (her door was locked). [V3] was in the room wandering. Both times writer told him this was unacceptable."

On 6/21/23 at 2:49 PM, V8 said she found V3 sleeping a couple of times. V8 said that V3 did disappear at times. V8 said staff are not supposed to sleep when residents are awake nor in residents beds.

On 6/21/23 at 11:51 AM, R3's room had a single bed in it. R3's bedroom door had the ability to be locked from the inside of the room.

The facility's Code of Ethics Policy and Procedure signed on 1/5/23 by V3 shows, "I will respect the privacy and dignity of the persons I serve and will show courtesy, patience, respect, gentleness,

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and compassion with regard to their care."
(B)
Two of two violations

330.4210a)
330.4240a)

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)

330.4240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These regulations were not met as evidenced by:

Based on interview and record review, the facility failed to ensure verbal abuse did not occur for one of three (R2) residents reviewed for abuse in the sample of three.

The findings include:

R2's Admission Record shows she was admitted to the facility on 5/5/22 with diagnoses including urinary tract infection, Alzheimers, and high blood pressure. R2's race is Asian.

R2's Care Plan dated 3/3/23 shows, "Impaired socialization interaction related to cognitive impairment. She has times when she is upset or angry. She speaks Korean most often and needs reminders to speak english. She has a variety of scenarios in her head which can trigger

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behaviors. Approach/Plan: Talk to her."

The facility's Employee Warning Notice dated 4/10/23 shows, "It was reported to me that [V3 CNA (Certified Nursing Assistant)] was mimicking a resident also yelling at the resident. As stated on page seven of the handbook, it states that no one is allowed to inflict pain or mental anguish to a resident. [Facility] does not tolerate, condone or allow resident abuse, mistreatment by anyone including staff members."

V6's CNA signed statement dated 4/10/23 shows, "[V3] was at the unit door. [R2] was speaking Korean so I walked and approached her and got her back onto the unit. [V3] was speaking to [R2] and [R2] wouldn't stop speaking Korean so [V3] starts yelling gibberish which lead to [R2] going behind the nurses cart reaching for the pill crusher to throw at [V3]. Then [V3] starts speaking gibberish more this time telling her to shut up which lead [R2] screaming to shut up [to V3]."

On 6/21/23 at 10:09 AM, V5 LPN (Licensed Practical Nurse) said when R2 gets mad, she yells in Korean. V5 said that V3 spoke "fake Korean" to R2. V5 said that R2 told V3 to shut up and then V3 spoke "fake Korean" again to R2 and at that point V5 gave V3 "a look" meaning to stop. V5 said she believes it made R2 more agitated when V3 was speaking in fake Korean. V5 said it is not ok for V3 to speak to R2 this way, making fun of her.

At 10:22 AM, V6 CNA said she witnessed R2 and V3 screaming at each other. V6 said that V3 was speaking "a bunch of gibberish" to R2. V6 said she looked at V3 and said "that's enough." V6 said she would never treat residents this way, that

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S9999	Continued From page 4 it is verbal abuse. The facility's Dignity and Respect policy not dated shows, "It is the policy of this facility that all residents be treated with kindness, dignity, and respect. The staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings." The facility's Abuse Policy and Procedure not dated shows, "Verbal abuse is defined as any use of oral, written or gestured language that includes disparaging and derogatory terms to residents or their families within hearing distance to describe residents regardless of their age, ability to comprehend or disability." (B)	S9999		