STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010136	A. BUILDING: _____ B. WING _____	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLIGHT HLTHCR OF WOODSTOCK	309 MCHENRY AVENUE WOODSTOCK, IL 60098

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S 000	Initial Comments Annual Certification and Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2): 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 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 by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. 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.	S9999		

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c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

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.

These requirements were not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure a resident's safety when in bed and failed to put interventions in place to protect a resident from injury. This failure resulted in R27 sustaining a fractured right ankle on 3/2/24. This applies to 1 of 18 residents (R27) reviewed for safety and supervision in the sample of 18.

The findings include:

1. The facility's undated initial incident report for R27 states, "On 3/2/2024, at approximately 7:00 PM, (R27) was in her room in her Broda chair resting comfortably, no agitation or discomfort noted by staff. When the CNA (V19) came into the room shortly after to render care, noted (R27) on the floor next to her bed. The nurse (V18) was immediately notified and assessed the resident. At this time, the resident was alert, complete body

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assessment was rendered with no visible injuries noted and ROM was at her baseline. There was no verbal or non-verbal indicators of pain or discomfort. Vital signs were within her normal. The NP, POA, and DON were notified. On 3/3/2024, at approximately 8:30 am, the nurse on duty noted edema to the right ankle and pain with minimal movement. The NP was notified, and an x-ray was ordered. The x-ray results stated, "possible incomplete fracture of the medial malleolus with follow up for confirmation." The NP and POA, were notified. The DON was notified on 3/4/2024. The NP ordered to secure the right ankle with ACE wrap until an immobilizer could be placed, as the resident is non-ambulatory. The DON contacted (X-Ray Company) on 3/4/2024, to confirm the result. The DON was instructed by the radiologist to repeat the x-ray, as the result was inconclusive. The POA was notified and requested the resident to be sent out to ED for further evaluation and x-ray. NP was made aware and with an order to send resident out to ED for further evaluation, per POA request. Resident sent out to ED per NP order and POA request. Resident returned to facility with a 3 view, x-ray result for "non dislocated fracture" of the right ankle. Investigation initiated and ongoing."

R27's Progress Notes dated 3/2/24- (Entered on 3/4/24) states, "CNA reported that he was assisting resident to bed. CNA stated that he left resident in Broda to retrieve a gown. When CNA reentered room, CNA observed resident lying on floor. LOC and ROM appropriate to baseline. Resident is nonverbal, however, no nonverbal signs of pain witnessed. Skin assessment was negative for any new injuries. Writer was notified. Writer assessed resident, no injuries noted, and no c/o pain. POA notified. NP and DON notified. BP 118/61 P 71 R 16. Will continue to monitor."

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S9999	Continued From page 3 R27's Nurse Practitioner Progress Note dated 3/4/24 states, "Patient is 64 y.o. woman with PMH (Past Medical History) of CAD (coronary artery disease), CHF (Congestive Heart Failure), hypertension, Presence of defibrillator, hypothyroidism, Alzheimer's with agitation and behavioral disturbances, depression/anxiety, Difficulty swallowing/dysphagia/anorexia. The patient suffers from acute and chronic medical/psychiatric illnesses which contributes to the patient's need for 24/7 assistance and skilled nursing care. Per nursing report, patient had a fall on 3/2/24. Initially, per nursing report, patient presented with no apparent injuries and no c/o pain. However, on the next day, patient started to c/o pain to right ankle and developed edema. Xray was ordered. Xray results came back on Sunday night with impression of possible R ankle/medial malleolus incomplete fracture. Immobilizer STAT and non-weight bearing were ordered after results review. This morning, this PCP (Primary Care Physician) collaborated with primary MD on the plan of care. Collaborated and discussed plan of treatment with DON. Patient is non ambulatory. She needs immobilizer and follow up with Ortho asap. Patient would need another Xray for fracture confirmation. Also, discussed with DON that POA needs to decide if he wants pt to be treated at the facility or wants her to be sent to ED for eval. According to DON, she communicated with POA, and POA decided that he wants patient to be sent out. Upon today's assessment, patient is found resting comfortable in her Broda chair with no s/s of pain or discomfort. She does have edema to right ankle. no bruising or discoloration, and no s/s suggestive of impaired circulation. Patient will be sent out to ED for trauma/injury evaluation."	S9999		

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R27's X-ray dated 3/5/24 shows that R27 has an "obliquely oriented non-displaced fracture through the base of the medial malleolus."

On 5/14/24 at 1:25PM V2 (Director of Nursing) stated, "(R27) was in her chair. We have to lay her back because she wiggles a lot in her chair. I've seen her do it. One time she did it we did get her a new chair because the brake did not engage, and she slid forward in the chair. It was an agency nurse and CNA when she fell- we are trying to get their phone numbers for you."

On 5/16/24 at 10:40 AM, V19 (CNA) stated, "I had just transferred her to the bed. It was in low position, like below my knees and I left the room to get her a gown because I was going to give her a bed bath. I was out of the room for only a few seconds and when I came back in her roommate told me she was on the floor. It was almost like someone flipped her out of the bed. Her head was at the foot of the bed. She seemed alright when we put her back in the bed. She rolled ok as I gave her a bed bath and I didn't see any bruising on her. It was 4 of us, 3 CNAs and the agency nurse (V18) that put her back to bed. The other nurse wouldn't come in the room because she said it wasn't her patient. I remember she walked half way down the hall and then she turned around. I don't remember seeing a floor mat in her room. That was my first time there and I have worked there, and I have been back about 3 times since then. I didn't know anything about her broken ankle."

R27's care plan dated 11/18/23 states, "(R27) had an actual fall related to sliding out of Broda chair. 2/11/24-fall out of Broda chair, 3/2/24- fall out of Broda chair, 5/2/24- fall rolled from low bed." Interventions added after the fall on 3/2/24

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S9999	Continued From page 5 include: Keep bed in lowest position while in bed, monitor resident's movements while in Broda chair as resident becomes restless at times, While in Broda chair, (R27 will be supervised by staff and Make frequent positioning checks while (R27) is in the Broda chair." On 5/13-5/15 a phone number for V18 (RN) was requested from the facility. The Nursing Agency was also called with request for R18's phone number. Both the facility and the Agency were unable to provide a phone number, therefore an interview with V18 could not be conducted. The facility's undated final Investigation Report regarding R27's fall states, "Per investigation the (facility) staff have explained the resident is noted to become fidgety at times and she changes her position in the chair frequently, as this can happen quickly, nursing has been instructed and interventions have been placed for the resident to be supervised by nursing/CNA, at all times while in the Broda chair..." (B) Statement of Licensure Violations 2 of 2): 300.615 e) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction	S9999		

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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)

These requirements were not met as evidenced by:

Based on interview and record review the facility failed to ensure criminal history background checks were initiated within 24 hours of admission. This applies to 2 of 10 residents (R179, R332) reviewed for background checks.

The findings include:

1. R332's Facesheet shows R332 admitted to the facility on 5/3/24.

R332's Criminal History Information Response registry form obtained from the state police department shows it a date of 5/6/24.

Facility provided electronic mail (email) communication between V11 (Social Services Director) and V22 (Corporate Background Checks) shows V11 emailed V22 on 5/4/24 to check the Criminal History Information Response registry for R332. V22 responded on 5/6/24 at 11:24 AM with a copy of R332's Criminal History Information Response registry form.

2. R179's Facesheet shows R179 was admitted to the facility on 5/4/24.

Facility provided electronic mail (email)

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S9999	Continued From page 7 communication between V11 (Social Services Director) and V22 (Corporate Background Checks) shows V11 emailed V22 on 5/4/24 to check the Criminal History Information Response registry for R179. V22 responded on 5/6/24 at 11:24 AM with showing that R179's criminal history record check was initiated on 5/6/24. V11 said she completes all other remaining background checks required. V11 said she will email V22 with a list of residents that have been admitted and V22 will respond with record showing the Criminal History Information Response registry was checked. V22's contact information was requested by the facility on 5/14/24 and was never received. Facility policy regarding background checks for residents was also requested by the facility and was never received. Facility Resident Admission Checklist form used by V11 shows that the Criminal History Information Response registry should be checked within 24 hours of admission. (C)	S9999		