Illinois Department of Public Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 01/26/2021 IL6001663 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1450 26TH STREET** HIGHLAND HEALTH CARE CENTER HIGHLAND, IL 62249 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) S 000 S 000 **Initial Comments** Complaint Investigation #2140474/IL130394 S9999 S9999 Final Observations Statement of Licenure Violations: 300.610a) 300,1210b) 300.1220b)2) 300.3240a) 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care Attachment A Statement of Licensure Violations 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

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6001663 01/26/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1450 26TH STREET HIGHLAND HEALTH CARE CENTER** HIGHLAND, IL 62249 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S9999 Continued From page 1 S9999 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status. sensory and physical impairments, nutritional status and requirements, psychosocial status. discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status. and drug therapy. Section 300.3240 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 REQUIREMENT WERE NOT MET EVIDENCED BY: Based on interview, and record review, the facility failed to allow residents to have end-of-life compassionate care visits from family for one of three residents (R2) reviewed for visitation in the sample of 7. This failure resulted in psychosocial

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PRINTED: 03/10/2021 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 01/26/2021 IL.6001663 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1450 26TH STREET** HIGHLAND HEALTH CARE CENTER HIGHLAND, IL 62249 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 Continued From page 3 S9999 On 1/25/2021 at 12:10 PM V10 LPN stated regarding compassionate care visits, "It is okay for family to visit residents." On 1/25/2021 at 12:20 PM V11 LPN stated regarding compassionate care visits, "Family has to be screened, and have on personal protective equipment (PPE) to visit an actively dying resident." On 1/25/2021 at 3:04 PM V5 Register Nurse (RN) stated, "I got report from (V7 LPN) night nurse". V5 stated. "I asked (V7) what to do if family requested to visit with (R2)." V5 stated that V7 responded "Staff are not allowing family visitations now due to if someone would contract COVID they may sue facility." V5 stated, "I went to give (R2) her morning medications and observed (R2) not doing well, so I called (R2's) daughter and advised her she needs to come to facility before 1pm as scheduled." V5 state "I was the first nurse in (R2) room." V5 stated, "It broke my heart. I put my cell phone on speaker so (R2's) daughter could speak to her mother." V5 stated the facility's policy and procedure is constantly changing so she's not sure about visitation and the communication is not good at the facility. V5 stated, "(V7) is part of the management team so I thought she would know."

Illinois Department of Public Health

On 1/25/2021 at 3:29 PM V7 LPN stated, "I worked midnights and gave report to (V5)." V7 stated that R2's breathing was declining, and she was still alive on night shift. V7 stated "(R2) was alert for me, made no complaints, and able to answer questions." V7 stated there was active dving residents that were allowed to have visitors. V7 stated, "I called (V2, Director of Nurse/DON) who stated, 'We are not allowing family visits

(X3) DATE SURVEY

Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		IL6001663	B. WING		C 01/26/2021
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 SHOUL D BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE	
S9999	Continued From page 4		S9999		
		stated, "I am not familiar with and procedure on family			
ijo	working another had come to R2's room window. V6 stated 'room so I quickly m could and left." V6 s (R2's) daughter did CNA stated, "The fa	34 PM V6, CNA, stated he was all and he heard a page to to move her bed closer to a was the only one in (R2's) woved her bed as fast as I stated, "I don't know why n't come inside facility." V6 acility's policy and procedure is with gown and mask on" ionate care visits.		8 9	
	stated regarding co "Absolutely, I would	31 AM V15, R2's Physician, mpassionate care visitation, expect the facility to follow cocedures on family visits."	12		
	had already passed was the second nur "Family was outside	:31 AM V16 LPN stated, "(R2) I, when I entered the room. I rse to confirm." V16 stated, e (R2's) window visibly upset." ere told by (V2) that visitors are			
	had many in service	15 PM V2 stated, "We have es on that." V2 stated, "I think aff member who doesn't work w the situation."			
	Life/Hospice Visitor considers COVID-1 When a resident is of end of life, family loved one. 3. When will be screened at	and Procedure, End of Policy, dated 4/1/2020, which 9 precautions documents "2. showing signs and symptoms will be permitted to visit their entering the facility, the family the door for temperature and s of COVID. 4. The family will	¥.		

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health

STATE FORM

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