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S 000	Initial Comments Investigation of Facility Reported Incident of 10/22/24/IL180248 Investigation of Facility Reported Incident of 11/2/24/IL180489	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 1 300.610a) 300.1210c) 300.1210d)6) 300.2210b)2) 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 c) Each direct care-giving staff shall review and	S9999		

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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.

Section 300.2210 Maintenance

b) Each facility shall:

2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems.

These requirements were not met as evidence by:

Based on observation, interview, and record review the facility failed to ensure an exit door with an audible alarm was in functional order and alerting staff when opened, and failed to ensure a resident with severe cognitive impairment and increased confusion was appropriately assessed and supervised to prevent elopement for 1 of 3 residents (R1) reviewed for elopement in the sample of 13.

The findings include:

R1's face sheet shows he is a 77-year-old male

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with diagnoses including unspecified dementia, COPD, hypertension, atrial fibrillation, and cerebral infarction.

R1's Final Incident Report dated 10/29/24 documents on 10/22/24 (R1) was noticed leaving his room on the "400" hall at 12:10 AM, and was last seen by staff at 12:30 AM, walking down the "100" hallway." Upon CNA (Certified Nursing Assistant) rounding at 1:00 AM, staff noticed (R1) was not in his room ...he is a long-term care resident with a diagnosis of dementia .... he is able to make to understand with a current BIMS (Brief Interview of Mental Status) of 6 (severe cognitive deficits). At approximately 12:00 AM, (R1's) nurse entered his room to turn of the TV. At approximately 12:10 AM, (R1) exited his room onto the 400 hall and proceeded to the 300/400 nurse's station. Per staff (R1) was stating "there was a black man in my room going through his stuff." Per CNA she stated, I attempted to inform the resident both my role and nurses' role, but (R1) appeared confused and upset ...(R1) returned to his room and came out with his jacket and proceeded past the 300/400 nurses' station to the main hall toward the dining room where he interacted with another female resident (R2). Per staff (R2) noticed (R1) appeared "distressed ...." R1 continued down the main hallway and arrived at the 100/220 hallway at approximately 12:15 AM .... R1 was last seen by staff at 12:30 AM walking down the 100 hallway. Upon rounding rooms at 1:00 AM, they could not locate R1. R1 was located at 2:05 AM outside of the facility with police.

On at 11/4/24 at 9:12 AM, V3 (Maintenance Director) said R1 exited the 100-exit door from the smoking area. The exit door should alarm when the door is opened. V3 opened the 100-exit

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door to the smoking patio. This was an enclosed patio with a gate and fencing around the back of the facility. V3 opened the gate from the patio by lifting the unsecured lock. To the left off the patio, and approximately 175 feet, was a double wired unsecured gate left wide open. The unsecured gate lead to the employee parking lot, and approximately 200 feet from that was a two-lane road. V3 said the double gate should be locked. The gate's lock was old and rusty. V3 attempted to close the gate with the rusty lock. The lock did not secure the double gates firmly. V3 moved the double gate and the gates opened easily. V3 stated, "I know it's it not the best, but that's how they lock it ...I think we could use an upgrade." V3 said staff open the gate to get supplies from the shed and forget to lock the gate.

On 11/4/24 at 11:18 AM, the 100-exit door had two alarms secured to the door. This surveyor pressed the handicap button located on the wall and the door opened without alarming. At 12:30 PM, with V1 (Administrator) at the 100-exit door, this surveyor pressed the handicap button located on the wall. The 100-exit door opened without alarming. Seven residents were outside on the patio without staff. V1 stated, "that means it was not re-activated (the alarm). The nurse is responsible for re-activating the alarm." V1 said the alarm did not go off.

On 11/4/24 at 9:30 AM, R1 was observed in his room with a wander guard on his wrist. He said they put this on me a couple of days ago to keep track of me. R1 said he left the facility and went for a walk to get a cup of coffee at the shell station. He said he found the gas station because it was lit up. He said he went out the back door and did not have any problems leaving, and the gate just opened. He said he did not hear the

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alarm when he opened the door. He said they "pissed me off" and they were not paying attention, and they did not know he was gone. R1 said he walked back, and the police were looking for him. He fell outside and was bleeding on his forehead. He said his right wrist was hurting from the fall. "It was no big deal." R1 said he was not sure how long he had been at the facility, he said maybe 4-5 weeks. He said he was in (Local City) and could not recall the date or year. R1 said he was not sure where he was from.

On 11/4/24 at 11:49 AM, R2 said she saw R1 the evening he left the facility in the hallway. R2 said R1 seemed to be agitated with the staff. He was complaining about V4 (Licensed Practical Nurse/LPN Agency) and V6 (Certified Nursing Assistant) being in his room snooping around. R2 told R1, V6 is the CNA who works here, and he knows her and V4 was his nurse. V4 is agency staff, she is familiar with him because he works at the facility sporadically. That evening she went out to smoke with R1 around 8:00 to 9:00 PM, without staff. Each smoker is a different level. R2 said she is a level one and can go outside anytime, R2 is a level two. She said when she goes outside, she presses the button on the wall to go out the 100-exit door to the smoking patio. The door opens automatically, and usually there is no alarm. R2 said she did not hear an alarm go off that evening when R1 left the facility. R2 said R1 was not himself that evening.

On 11/4/24 at 10:29 AM, V6 (CNA) said she was R1's CNA when he left the facility on 10/22/24. She said V4 went into his room looking for the TV remote. R1 came out of his room and was upset, he said there is black guy going through my stuff and kept repeating it. She told him V4 was his nurse. R1 said he didn't know V4 and told me he

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didn't know who she was either. R1 went back to his room, got his jacket, and said he was going to call the police. She also saw him talking to R2. She was doing her rounds and saw him on the 200 wing. R1 told the staff on the 200 wing he was going to call the police. She said she answered a call light and when she was done assisting the resident, she could not find R1. The last time she saw R1 was about 12:30 AM, she walked outside around the facility and did not see him. V6 said the alarm did not go off, she did not hear any alarm. She said the alarm should set automatically and there is nothing they need to do with the alarm. About 2:00 AM, R1 was found outside with the police in front of the building. R1 said he went to the gas station to get a cup of coffee and fell outside. He had a bruise on his arm and mark on his head.

On 11/4/24 at 1:14 PM, V7 (CNA) said she was working the 200 hall when R1 left the facility on 10/22/24. R1 was from the 400 wing. He came to the 200 wing late and said strange people were in his house that he had not seen before. R1 was confused, she told him to go back to his room and get some sleep. She said she answered a call light and when she came out of the room, R1 was not there. The staff said they could not find R1. We searched the facility and could not find R1. She left in her car looking for him outside and could not find him. The 100-exit door has an alarm, and she did not hear the alarm go off. Residents can outside to smoke from the 100-exit door, the door should be locked and alarmed. R1 is forgetful, that night he seemed more forgetful. He is not safe to be outside and needs to be supervised.

On 11/4/24 at 2:31 PM, V5 (RN-Registered Nurse) said sometime after midnight R1 was at

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the 100/200 nurses station trying to re-direct him back to his room. He came about 15 minutes later, and staff reported they could not locate R1. We were not able to locate R1. The police found R1 outside of the facility, when he returned, he had an abrasion to his forehead. R1 is alert with confusion but seemed more confused that evening. The 100- exit door alarms if a resident has a wander guard on and the door opens. A lot of residents go out the 100-exit door to smoke, they go out all night with no time restriction and the door does not alarm when they go out.

On 11/4/24 at 12:19 PM, V1 (Administrator) said he was notified by phone on 10/22/24 about 1:45 AM, R1 eloped. He arrived at the facility about 2:05 AM, R1 was outside with the police. We inspected all the doors to find out what happened. The 100-exit door alarm was not functioning. The alarm should go off when the door opens. Leading up to R1 leaving he was agitated; he left the facility about 12:30 AM. R1 said he left to get a cup of coffee and returned to facility and fell outside.

On 11/4/24 at 12:56 PM, (Director of Nursing-DON) said on 10/22/24 she was notified about 1:00 AM, they could not locate R1. Staff reported R1 had increased confusion and was seen getting his jacket and on the 100 unit where the exit doors are to the smoking patio. V1 saw him on video leaving the 100 exit doors and going towards the left of the building. The police were called and found R1 in front of the facility. R1 reported he wanted to get a cup of coffee. R1 fell outside and was complaining of wrist pain and had an abrasion to his forehead. He was sent out to the local hospital and was diagnosed with a urinary tract infection. R1 has cognitive deficits, is forgetful, ambulates with a walker, and he needs

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supervision when smoking and out in the community for safety. R1 crossed the main road to get to the gas station. He shuffles when walking and is not steady. She would expect staff to ensure a resident is safe when they are agitated or change in cognition.

On 11/6/24 at 3:00 PM, V1 said he reviewed the video and confirmed R1 was seen exiting the 100-exit door onto the patio and turned to the left where the double gates are located near the main street.

On 11/8/24 at 10:38 AM, V1 said V3 measured the distance from the patio to the double gate at 175 feet and from the gate to the street is 200 feet.

On 11/8/24 at 9:05 AM, V10 (Nurse Practitioner) said she was notified about the elopement. R1 is alert with forgetfulness, he sustained a fall outside with a forehead abrasion. He was sent out and diagnosed with a urinary tract infection. She would expect staff to report a change of cognition and monitor the resident for safety.

R1's nurses note dated 10/22/24 documents at 12:05 AM, during rounds, (R1) was confused and wanted to know why this writer (V4-Licenced Practical Nurse) was in his room. (V4) explained to R1 he was his nurse. (R1) was unable to be redirected and was observed walking down the 100/200 hall nursing station. Art 12:25 AM, (R1) was talking to 100/200 staff ...Staff reported (R1) was complaining about a black man and walked down the 100 halls ...R1 could not be located in the facility ....at 2:00 AM, R1 was located with the police.

R1' nurses note dated 10/22/24 by V21 (RN)

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documents received in report, (R1) eloped last night and returned around 2:00 AM with bruises, abrasions, and pain ...bruises to skin, abrasion to right forehead and swelling to right hand ...(R1) was sent out to the local hospital and returned with diagnosis of urinary tract infection.

R1's care plan dated 11/2/23 documents his memory is impaired and has problems with decision-making, insight, logic, calculation, and reasoning, planning and judgement. R1's BIMS scored a 6 out of 15, he is confused and requires cues and reminders. R1 demonstrates movement behavior that may be interpreted as wandering pacing or roaming related to the diagnoses of dementia and problems understanding the immediate environment. R1 can get agitated with staff when redirected. Staff should assess for potential elopement/unauthorized departure risk, make rounds/room checks ...R1 is a smoker and requires supervision when smoking.

R1's Community Survival Skills dated 9/17/24 documents he does not appear to be capable of unsupervised pass privileges.

The facility's undated timeline report shows at 12:10 AM, (R1) walked out of his room by the 300 nurse's station. At 12:12 AM, (R1) walked down main hall, he stopped at the dining room and spoke with R2. At 12:15 AM, (R1) was at the 100-nurse station talking to CNA's. At 12:29 AM, (R1) left the nurses station and walked down the 100 halls. At 12:30 AM, (R1) exited the building to smoking area and did not stop. At 2:05 AM, (R1) located.

The facility's Door Alarm Test Log dated October 2024 shows on 10/22/24 "FAIL" for 100 Wing Exit and 300 Wing Exit. "Note: Replace alarms in wing

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S9999	Continued From page 9 100 exit and wing 300 exit." The facility's undated Door Alarm Policy and Procedure states, "To prevent elopement and thus secure the safety of wandering clients, it is the policy of this facility to have an alarm on all exit doors accessible to clients. 1. All exits are alarmed and are installed at the following locations: a. the front door, b. the exit doors on the 100, 200, 300 and 400 halls ...the maintenance director and/or designee will check all doors with an alarm daily to ensure they are in working order ..." The facility's Elopement and Wandering Residents revised 12/23 states, "This facility ensures that residents who exhibit wandering behaviors and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their personal centered plan of care addressing the unique factors contributing to wandering or elopement risk ...the facility is equipped with door alarms to help avoid elopements ...this facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary." (A) 2 of 2 300.610a) 300.1210b) 300.1210d)6)	S9999		

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S9999	Continued From page 10 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 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. 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.	S9999		

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These requirements were not met as evidence by:

Based on observation, interview, and record review the facility failed to ensure a resident (R3) was free of physical abuse by a resident (R4) with known aggressive and verbal behaviors. This failure resulted in R3 not feeling safe in the facility. This applies to 3 of 3 residents (R3, R4, R5) reviewed for abuse in the sample of 11.

This failure resulted in R3 experiencing pain and fearfulness.

The findings include:

On 11/6/24 at 9:25 AM, R4 was seen self-ambulating in R4's room and throughout the 100 unit hallway. R4's room is directly across the hallway from R3's room. R3 was seen in R3's room in R3's wheelchair.

On 11/6/24 at 10:44 AM, V12 (Certified Nursing Assistant- CNA) said R4 is frequently confused related to a diagnosis of dementia and that R4 wanders the facility. V12 also said R4 has a history of being aggressive in the evenings towards both staff and residents. V12 said R4's aggression has slowly escalated through time and has gotten worse.

R4's Care Plan focus initiated on 4/29/24 states, "[R4] has a behavior problem: Making statements that people are taking items from her room without her permission... Losing and misplacing items then thinking that they were taken by others... Raising her hand to hit staff or peers when she gets agitated. 9/13/24- Suicidal ideations. 9/20/24- Hit other resident. 11/2/24-

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Physically aggressive toward another resident."

Facility incident report dated 10/29/24 shows R3 and R4 got into a verbal altercation. Per the report, R4 was seen closing R3's door against R3's preference. R3 and R4 were then seen in the hallway in a verbal altercation, understandable individually to themselves. The report states that R3's television was too loud and other residents complain about it.

On 11/6/24 at 10:44 PM, V12 stated she was working the evening shift on 10/29/24 and witnessed the verbal altercation between R3 and R4. Per V12, R4 entered R3's room and a verbal argument between R3 and R4 began. V12 and other staff separated R3 and R4 from one another and continued to keep them separated the rest of V12's shift.

On 11/6/24 at 2:01 PM, V2 (Director of Nursing) said the only interventions implemented after the incident on 10/29/24 were resident redirection and to keep R3 and R4 separated.

On 11/6/24 at 9:25 AM, R3 said she was attacked by another resident (R4) the other day (11/2/24). R3 said R4 walked across the hallway into R3's room and attempted to pull R3's hair. R3 pushed R4 away and R4 slapped R3 across the face. R3 stated her face hurt after the slaps and that R4 is much stronger than she appears. R3 then grabbed a fly swatter from her bedside table and began swinging at R4, trying to hit R4. R3 said staff came and separated the residents. R3 said R4 wanders the hallways in the evening and R3 has seen R4 enter other resident's rooms. R3 stated the facility did not move R4 to another room and she does not feel safe in the facility during the evenings since it can take up to one or

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 _____	C 11/12/2024

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

(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 13	S9999		

two hours for staff to respond to call lights after 10:00 PM.

On 11/6/24 at 1:30 PM, V15 (CNA) said on 11/2/24, V15 was going to the 100 hall shower room. When exiting the shower room, V15 saw R3 exit R3's room wielding a fly swatter and R3 began hitting R4 with the fly swatter. R4 then retaliated and slapped R3 on the face. V15 and V14 (Registered Nurse/RN) separated R3 and R4. V15 was aware of the prior verbal altercation between R3 and R4. V15 said that R4 can be mean and has a history of being mean towards staff. R4 has slapped V15 on the shoulder before. V15 said R4 can sometimes be easily redirected but some days, including on 11/2/24, R4 can be difficult to redirect. V15 said there have not been any other altercations between R3 and R4 since 11/2/24.

On 11/6/24 at 1:36 PM, V14 said she only works at the facility on Saturdays and sometimes other days if she picks up additional shifts. V14 did not hear about the 10/29/24 altercation between R3 and R4 until after the incident on 11/2/24. V14 said after separating R3 and R4, V14 brought R4 to the 100 unit nurse's station. While at the 100 nurse's station, R4 accidentally bumped into R5 who was in her wheelchair by the 100 unit nurse's station and R5 pushed R4. V14 then assessed R3, R4, and R5 after the incident and stated none of the residents had any injuries, bruises, or lacerations. V14 then sent R5 back to the 400 unit, monitored R4 in the activity room and R3 was in R3's room. V14 told R3, R4, and R5 that their behaviors and actions were not okay. V14 then told the manager on duty that day who notified V1 (Administrator).

On 11/6/24 at 1:50 PM, V1 said he arrived to the

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S9999	Continued From page 14	S9999		

facility within an hour of the incident and got statements from staff and residents. V1 then filled out the incident form and sent it to the state agency. V1 said that R3 and R4 have had "words" before related to the volume of R3's television. At the time of the 11/2/24 incident, staff were providing redirection to R4. V1 said that the facility did not move R4 after the incident on 11/2/24 because R4's family requested to assist with the room transfer and was available on 11/6/24.

On 11/6/24 at 10:12 AM, V11 (Housekeeping Supervisor) and V13 (R4's Family Member) were seen moving R4's belongings to room 309, on the other side of the facility from R4's current room on the 100 unit.

Facility Abuse, Neglect and Exploitation policy dated 6/2024 states, "... The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: ... D. The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect;..."

(B)