	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IL6015044	B. WING		10/	09/2024
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IIGHVIE	W IN THE WOODLAN	DS	LCON POINT P DN, IL 61072	PLACE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S 000	Initial Comments		S 000			
	Annual Licensure S	urvey				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations 1 of 2				
	330.710 a) 330.710 c)3)F)					
	Section 330.710 R	esident Care Policies				
	procedures governi facility. The written be formulated with administrator. The followed in operatin reviewed at least ar	have written policies and ng all services provided by the policies and procedures shall the involvement of the written policies shall be g the facility and shall be nually by the Administrator. omply with the Act and this				
	c) The written polici limited to, the follow	es shall include, but are not ⁄ing provisions:				
	strategies to contro nurses and other he with the lifting, trans movement of a resi	fy, assess, and develop I risk of injury to residents and ealth care workers associated sferring, repositioning, or dent. The policy shall that, at a minimum, includes				
	injury to residents a care workers assoc	strategies to control risk of and nurses and other health iated with the lifting, ioning, or movement of a				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			FLETED
		IL6015044	B. WING		10/	09/2024
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IIGHVIE	W IN THE WOODLAN	IDS	LCON POINT P DN, IL 61072	LACE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
S9999	Continued From pa	ige 1	S9999			
	This REQUIREMENT was not met as evidenced by:					
	review the facility fa residents (R1, R3) failed to ensure a re footwear to prevent	ion, interview, and record ailed to properly transfer two with a history of falling and esident (R1) had proper t a fall. These failures affect 2 wed for falls on the sample list	t			
	Findings include:					
	activity area. R1 wa her walker. R1 had (CNA - Certified Nu a wheelchair and to toileting V5 (CNA) p her walker, parked brakes on the whee front of her and inst a gait belt around h gait belt on R1 to a position. V5 position wheelchair and pull R1 to a standing po continue walking to small steps to slow without a gait belt of hurt. V5 told R1 tha her arm wasn't brok	20 AM, R1 was m the hallway toward the as taking small, slow steps with to go to the bathroom. V5 ursing Assistant) assisted R1 to bok R1 to the bathroom. After bushed R1 in the wheelchair to in the hallway. V5 locked the elchair, placed R1's walker in tructed R1 to stand up. V5 had her waist. V5 did not place the ssist her to a standing ned herself behind R1's led up on R1's pants to assist bosition. V5 instructed R1 to the activity. R1 took very ly walk to the activity room, on. R1 told V5 that her arm at she went to the hospital and ken, but it would probably be e. At 11:40 AM, R1 was				
	R1 up and told her opened her eyes ar set R1's walker in f	h in the activity room. V5 woke it was time for lunch. R1 nd looked around the room. V5 ront of her and instructed her and stared blankly. V5				

STATEMEN	Pepartment of Public IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		IL6015044	B. WING		10/	09/2024
NAME OF F	PROVIDER OR SUPPLIER	•	DDRESS, CITY, ST	TATE, ZIP CODE	• • • •	
лспліе	W IN THE WOODLAN	1000 FA	LCON POINT P	LACE		
		ROCKTO	DN, IL 61072			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	nge 2	S9999			
	forward and attemp up on the back of h off the couch, but s fell back into the co [R1], I need you to rocking motion, V5 pants and R1 stood on R1, it was still at take small unstead Licensed Practical with her wheelchair V5 stopped R1 and	ctions to R1. R1 rocked bed to stand, while V5 pulled ber jeans. R1's bottom came he was unable to stand and buch. V5 stated, "I can't do it al help me." They repeated the pulled on the back of R1's d. V5 did not place a gait belt round V5's waist. R1 started to y steps forward. V7 (LPN - Nurse) told V5 to follow R1 because she was unsteady. I said, "you seem weaker the gait belt around her and sa eelchair.				
	(POS) showed R1	Physician's Order Sheet had diagnoses to include, but oporosis, seasonal allergies, Alzheimer's, and				
	was walking R1 to without socks and s present. This form 9/30/24. The note s pain in her right arn This form showed I shoulder pain and y with standing and T pain. R1 had a pres	rt dated 9/29/24 showed CNA the bathroom with her walker shoes. R1 fell with the CNA showed Fall Follow-up on showed R1 was complaining of n when she was transferring. R1 was complaining of right yelling in pain. R1 had difficulty ylenol was administered for vious Incident Report dated itnessed fall in her room.				
	Director of Nursing walking with a residen hands on a residen should have a gait	PM, V2 (Interim DON -) said if a staff member is dent or needs to put their It to assist, then the resident belt on. V2 said a gait belt nave a firm grip on the residen	t			

	partment of Public OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		IL6015044	B. WING		10/	09/2024
IAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
IIGHVIEW	IN THE WOODLAN	DS	CON POINT P N, IL 61072	PLACE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	f a resident starts to control the fall to po- minimize the injurie not pull residents up the gait belt is for. No that." V2 said before bathroom, the CNA wear (gripper socks resident. V2 said the floors and they floor doesn't have footwe she usually works a but usually requires members. V2 said the right shoulder pain wasn't working whe ncidents. V2 said R froom after the fall, I found. V2 said R1 re been complaining of On 10/8/24 at 3:00 assisting R1 the mo- fell). V8 said R1 was screaming. V8 said and started to wobs tried to stop R1 from said the nurse calle to the hospital. V8 so per socks when she before she fell, ther screamed when sho wheelchair and the On 10/8/24 at 2:50 working the day R1	keeping their balance. V2 said o fall, then the staff can otentially prevent and/or s. V2 said the CNAs should p by their pants, that's what /2 stated, "They should know e taking a resident to the should ensure proper foot s or shoes) are on the e facility doesn't have carpet rs are like ice if the resident ear with grip on them. V2 said at night and R1 can ambulate, the assistance of two staff R1 had been complaining of since she fell. V2 said she en R1 fell, but she reviews the R1 was sent to the emergency but there were no fractures returned to the facility, but had of right arm pain since the fall. PM, V8 (CNA) said she was prining of 9/29/24 (when R1 is getting out of bed and R1 was holding her walker ole back and forth. V8 said she in falling, but she couldn't. V8 is d the ambulance and R1 went said R1 wasn't wearing shoes fell. V8 said R1 screamed in was quiet for a while, but e was transferred to the	S9999			

(EACH DEFICIENC' REGULATORY OR L ontinued From particular ontinued From particular on the floor, on her noes on. V7 state dn't have shoes of n unsteady gait. I bout that." V7 said 1. V7 said R1 was ain. In 10/9/24 at 9:47 ne was unable to plicy. V1 said she was driving her of 1 said she provide	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) Age 4 To butt and had no socks or d, "I asked [the CNA] why sh or socks on because she has had to re-educate the CNA d she didn't see a gait belt or s complaining of right should AM, V1 (Administrator) said locate the facility's gait belt knew the facility had one an razy that she couldn't locate ed checklists to show that the	B. WING ADDRESS, CITY, S ALCON POINT I FON, IL 61072 ID PREFIX TAG S9999 e er er		CORRECTION ON SHOULD BE HE APPROPRIATE	09/2024
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she was unable to l policy. V1 said she it was driving her cr V1 said she provide CNAs are expected	and ambulation with the				
updated 8/20/20) s f all fall risks and a nd of alarm/floor roperly use his/he p properly transfer om chair to whee	Fraining Check Off List showed, "8. Trainees award any resident that may have a mat 17. Trainee is able to r gait belt. 18. Trainee is able from wheelchair to chair and lchair 22. Trainee is able to a resident with a walker and	ny 9 I			
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hositiysoc hro	e facility's Safety licy showed, "6 sistance/appropr ng/transferring a ou have any dou k your superviso the task. Asking duces the chance e facility's undate ogram showed, '	e facility's Safety Responsibility and Rules licy showed, "6. Always have sistance/appropriate safety equipment when ng/transferring a resident. Do not begin a tas ou have any doubts as to how it is to be done k your supervisor to determine the safe way t the task. Asking for help when you are unsur duces the chance of injury" e facility's undated Safe Patient Handling ogram showed, "Scope: Whenever a resident quires assistance in moving or transfer at [the	e facility's Safety Responsibility and Rules licy showed, "6. Always have sistance/appropriate safety equipment when ng/transferring a resident. Do not begin a task ou have any doubts as to how it is to be done. k your supervisor to determine the safe way to the task. Asking for help when you are unsure duces the chance of injury" e facility's undated Safe Patient Handling ogram showed, "Scope: Whenever a resident quires assistance in moving or transfer at [the	e facility's Safety Responsibility and Rules licy showed, "6. Always have sistance/appropriate safety equipment when ng/transferring a resident. Do not begin a task ou have any doubts as to how it is to be done. k your supervisor to determine the safe way to the task. Asking for help when you are unsure duces the chance of injury" e facility's undated Safe Patient Handling bgram showed, "Scope: Whenever a resident quires assistance in moving or transfer at [the cility] this policy will be followed. Purpose: This	e facility's Safety Responsibility and Rules licy showed, "6. Always have sistance/appropriate safety equipment when ng/transferring a resident. Do not begin a task ou have any doubts as to how it is to be done. k your supervisor to determine the safe way to the task. Asking for help when you are unsure duces the chance of injury" e facility's undated Safe Patient Handling ogram showed, "Scope: Whenever a resident quires assistance in moving or transfer at [the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER IL6015044 B. WING 10/09/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10/09/2024 HIGHVIEW IN THE WOODLANDS 1000 FALCON POINT PLACE ROCKTON, IL 61072 VING VING	Illinois D	epartment of Public	Health			FORM	APPROVED
NNE OF PROVIDER OR SUPPLIE STREET ADDRESS. CTV, STATE, ZIP CODE 1000 FALCON POINT PLACE MARE OF PROVIDER OR SUPPLIER STREET ADDRESS. CTV, STATE, ZIP CODE 1000 FALCON POINT PLACE MARE OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEPICIENCIES. DEPICIENCY OWID CONTROL SECTION (L. GROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) DEFICIENCY CONSERCEMENT OF THE APPROPRIATE DEFICIENCY S9999 Continued From page 5 S9999 S9999 Continued From page 5 S9999 S001000 Continued From page 5 S9999 Continued From page 5 S9999 Continued From page 5 S9999 S00100 Continued From page 5 S9999 Continued From page 5 S9999 Continued From page 5 S9999 S0010 Continued From page 5 S9999 Continued From page 5 S9999 Continued From page 5 S9999 S0010 Continue France S9099 Continued From page 5 S9999 Continued From page 5 S9999 S0010 Continue France S9099 Continued From page 5 S9999 Continued From page 5 S9999 Continue France S9010 Continue France S9010 Continue France Continue France </th <th>STATEMEN</th> <th>IT OF DEFICIENCIES</th> <th>(X1) PROVIDER/SUPPLIER/CLIA</th> <th></th> <th></th> <th></th> <th></th>	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
Bigs PALCON POINT PLACE TROCKTON, IL 61022 March Distribution of Connection Security of Connesta and R35 back security of Connest of Connection Secur			IL6015044	B. WING		10/	09/2024
MICH WIN THE WOODLANDS ROCKTON, IL 61072 0400 THEX TAG SUMMARY STATEMENT OF DEPENDENCE SUMMARY STATEMENT OF DEPENDENCE SUMMARY STATEMENT DE PRECEDER SETUL RECULATORY OR LSCIENTFYING INFORMATION PRETX TAG PROVIDERS PLAN OF CONFERCION OF LOD PRETX TAG PROVIDERS PLAN OF CONFERCION PLAN OF CONSERVED STATEMENT OF PRETX PROVIDERS PLAN OF CONFERCION OF LOD PRETX TAG PROVIDERS PLAN OF CONFERCION PLAN OF CONSERVED STATEMENT OF PLAN OF CONFERCION PLAN OF CONFERCION OF LOD PRETX TAG PROVIDERS PLAN OF CONFERCION PLAN OF CONFERCION OF LOD PRETX TAG PROVIDERS PLAN OF CONFERCION PLAN OF CONFERCION OF LOD PRETX PROVIDERS PLAN OF CONFERCION OF LOD PRETX TAG PROVIDERS PLAN OF CONFERCION PLAN OF CONFERCION OF LOD PRETX PROVIDERS PLAN OF CONFERCION OF LOD PROVIDERS PLAN OF LO	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	·	
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TAG TEACH DEFICIENCY MUST BE PRECEDED BY FULL REDULATORY OR US DIENTIFYING INFORMATION) PREFIX TAG CEACH DEFICIENCY COMPLET TAG 59999 Continued From page 5 S9999 S9999 Solid From page 5 S9999 Solid participation Solid Previous Solid From Page 5 S9999 Solid From page 5 S9999 Solid participation Solid From Page 5 S9999 Solid From Page 5 S9999 Solid participation Solid From Page 5 Solid From Page 5 Solid From Page 5 Solid participation Transferring or moving, through the consistent use of mechanical aids/devices and/or safe manual lifting and moving techniques and to meet regulatory requirements Definitions:Safe lifting equipment means mechanical stand itts, side sheets and boards, slings, wheelchairs, commode chairs, shower benches, toiletting chairs, gait betis/transfer betis and repositioning/turning sheets 2. On 10/8/24 at 11:43 AM, R3 was sitting in a recliner in the activity room. VS (CNA) informed R3 that it was time for lunch. The surveyor walked to the dining room to observe the noon meal, but the trays had not arrived. Upon returning down the hallway, tvS was walking backwards, pulling R3 in a wheelchair. The wheelchair had no foot rests and R3's black sneakers were dragging on the floor. R3's sneakers occasionally squeaked from dragging on the floor. V5 took R3's wheelchair backwards from the activity room, down the hall, into the pink dining room. R3's feet dragged on the floor the entire time. R3's Corber 2024 POS showed he had diagnoese to include, but not limited to:			ROCKTO	N, IL 61072			
policy has been developed to protect the health and comfort of residents and employees when residents require assistance in transferring or moving, through the consistent use of mechanical aids/devices and/or safe manual lifting and moving techniques and to meet regulatory requirements Definitions:c. "Safe lifting equipment" means mechanical equipment designed to lift, move, reposition, and transfer residents, including, but not limited to: mechanical full-body lifts, mechanical sit to stand lifts, side sheets and boards, slings, wheelchairs, commode chairs, shower benches, toileting chairs, gait belts/transfer belts and repositioning/turning sheets 2. On 10/8/24 at 11:43 AM, R3 was sitting in a recliner in the activity room. V5 (CNA) informed R3 that it was time for lunch. The surveyor walked to the dining room to observe the noon meal, but the trays had not arrived. Upon returning down the hallway, the surveyor passed V5 in the hallway. V5 was walking backwards, pulling R3 in a wheelchair. The wheelchair had no foot rests and R3's black sneakers were dragging on the floor. R3's sneakers occasionally squeaked from dragging on the floor. V5 took R3's wheelchair backwards from the activity room, down the hall, into the pink dining room. R3's feet dragged on the floor the entire time. R3's October 2024 POS showed he had diagnoess to include, but not limited to: diabetes, hypertension, dementia, and pain. R3's Incident Reports dated 3/11/24, 5/14/24, 8/7/24, and 9/19/24 showed he had falls with no injuries. R3's Care Plan initiated 8/23 showed he had an	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETE
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nois Department of Public Health		8/7/24, and 9/19/24					
			ated 8/23 showed he had an				
				6899	91Q211	If continue	tion sheet 6 of

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		IL6015044	B. WING		10/	09/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	·	
HIGHVIE	W IN THE WOODLAN	IDS	LCON POINT P DN, IL 61072	LACE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ige 6	S9999			
	alteration in mobility needed.	y and used a wheelchair as				
	Director of Nursing R3 backwards in a dragging. V2 said h of the wheelchair. V and ambulates well don't understand w he was in a hurry for	PM, V2 (Interim DON -) said it's not safe to transfer wheelchair, with his legs he could have flipped right out /2 said R3 is still pretty strong I. V2 stated, "He likes to walk. hy they would do that, unless or some reason." V2 said they pulled the wheelchair t. It's not safe.	Ι			
		(B)				
	Statement of Licen	sure Violations 2 of 2				
	330.1160c) 330.1160d)					
	Section 330.1160	Vaccinations				
	administration of a each resident in ac recommendations of Immunization Pract Disease Control an received this immu admission to the fa refuses the offer fo	of the Advisory Committee on tices of the Centers for d Prevention, who has not nization prior to or upon cility unless the resident r vaccination or the cally contraindicated. (Sectior	n			
	medical record that pneumococcal pne administered, arrar	cument in each resident's a vaccination against umonia was offered and nged, refused, or medically Section 2-213(b) of the Act).				

STATEMEN	epartment of Public IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
HIGHVIF	W IN THE WOODLAN	IDS	CON POINT P	LACE		
		ROCKTO	DN, IL 61072			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ge 7	S9999			
	This REQUIREMEI	This REQUIREMENT was not met as evidenced by:				
	Based on interview and record review the facility failed to ensure pneumococcal vaccination status were documented, failed to ensure pneumococcal vaccinations were administered, and failed to ensure pneumococcal vaccinations were tracked in the medical record for 2 of 5 residents (R1, R7) reviewed for vaccinations on the sample list of 7.					
	Findings include:	Findings include:				
	Pneumococcal vac residents from V1. Director of Nursing for the 5 residents. oversees the Immu "very interim" DON nights. V2 said she incidents and ensu Movement Scale (A completed, but has with immunizations covering as "interim said she thought th the pneumonia vac came in to give the Services) was work said there should b last received the van next, but she is not said she doesn't thi pneumonia vaccine residents are admit	AM, the surveyor requested cination records for 5 At 2:13 PM, V2 (Interim DON -) provided various documents The surveyor asked V2 if she inizations. V2 said she is the . V2 said she works full-time reviews the accidents and res the Abnormal Involuntary AIMS) assessments are not had time to do anything . V2 said she had been n DON" since June 2024. V2 e residents may have received cines when the pharmacy flu shots. V2 said V3 (Social ting with the pharmacy. V2 e records of when the resident accines and when they are do tracking this information. V2 nk anyone is tracking the ted the nurse is supposed to on history and document it. V2				

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NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HIGHVIE	W IN THE WOODLAN	IDS	LCON POINT F DN, IL 61072	PLACE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	age 8	S9999			
	symptoms if a resid	the risk of more severe dent does get ill. V2 stated, nts are willing to get the				
	she is helping obta upcoming flu clinic. DON handled most to help. V3 said she pneumococcal vac anything with them previous DON] talk vaccines, but she r V3 said she was no often the pneumoc given. V3 said there with how the facility aware that there ar	AM, V3 (Social Services) said in the consents for the . V3 said last year the previous t of it, but this year she is trying e doesn't know much about the cines and she's not doing . V3 stated, "Last year [the red about having pneumonia never followed through with it." of a nurse and was unsure how occal vaccines needed to be e isn't a consistent process / handles the vaccines and is re several different forms being e's not sure who is overseeing "maybe [V2]?")) /			
	the pneumococcal the resident's physic then the nurses' co said the facility didr the pneumococcal done a clinic for the said the nurse shout about their immuniz admission process form that would be "The Nursing Admis surveyor showed V Assessment (the var	AM, V1 (Administrator) said vaccines would be tracked by ician and if it was ordered, build administer the vaccine. V1 n't have a process in place for vaccine and they had never e pneumococcal vaccines. V1 uld be asking the residents zation history during the . The surveyor asked what documented on. V1 replied, ssion Assessment." The (1, R3's Nursing Admission accine history was not form) and asked where it was				
	documented. V1 sa knew she'd seen it	form) and asked where it was aid she wasn't sure, but she before. At 10:12 AM, V1 ference room with R3's				

llinois D	epartment of Public	Health	-		r	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		IL6015044	B. WING		10/	09/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	ge 9	S9999			
	"This is what the nu The surveyor asked R3 received the Pn she received it last. document was lack information as well. R3's Physician Med 8/25/2020 showed, every 10 years or a	ding Orders Form and stated, arse should be completing." d where it is documented that eumococcal vaccine or when V1 replied, "It doesn't." R7's ing the Pneumococcal V1 replied, "I see." dication Standing Orders dated "6. Pneumococcal vaccine s otherwise ordered (last _)" The date it was last				
	signed 8/31/20 sho prospective and cu recommendation for an annual Influenza vaccine at an interv family physician. W immunization status areas at the time of need of either vacc permission from yo your doctor for you appropriate. It is yo vaccination, howev	ad Influenza Vaccine Policy wed, "[The facility] advises all rrent residents on the or all elderly persons to receive a vaccine and Pneumonia ral recommended by your e will inquire as to your s in both of the above listed f your admission. If you are in ination, we will obtain u or your representative and to receive the vaccination as ur right to refuse either er it is seriously recommended em" R3's Pneumo received as were blank.				
	R7's Facesheet sho	owed he was admitted 2/11/23				
		nd Influenza Vaccine Policy wed the Pneumonia shot e lines were blank.				
	Techniques/Policies "Admissions - Co	ed Infection Control s and Procedures showed, mmunicable				
ois Depar	tment_of Public Health M		6899 01	IQ211	If continuati	on sheet 10 d

STATEMEN	epartment of Public T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVE COMPLETED	
		IL6015044	B. WING		10/	09/2024
					10/	09/2024
	PROVIDER OR SUPPLIER	1000 FAL	CON POINT	STATE, ZIP CODE PI ACF		
IIGHVIE	W IN THE WOODLAN	IDS	N, IL 61072			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
S9999	Continued From pa	age 10	S9999			
	facility that admissi facility's ability to pr nursing care. The f adequate care is th admitting, or not ac known communica Procedure: 1. Upor	Purpose: It is the policy of this on is dependent upon the rovide appropriate medical and acility's ability to provide the predominant criteria in dimitting, a resident with a ble disease or infection. In admission, the resident will Pneumococcal vaccine status, (B)				
ois Depar	tment of Public Health					