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	IL6010136	A. BUILDING: _____ B. WING _____	C 03/18/2025

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HIGHLIGHT HLTHCR OF WOODSTOCK	309 MCHENRY AVENUE WOODSTOCK, IL 60098

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S 000	Initial Comments Complaint Investigation: 2512310/IL188291 2512424/IL188445	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The	S9999		

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facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure dietitian recommendations for an increased tube feeding order were carried out. This failure resulted in R8 experiencing a significant weight loss of 13.9% in 6 months. This applies to 1 of 3 residents (R8) reviewed for weight loss in the sample of 15.

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The findings include:

R8's Face sheet dated 3/18/25 shows R8 has diagnoses that include but are not limited to: dysphagia following cerebral infarction, acute metabolic acidosis, and abnormal weight loss.

On 3/17/25 at 12:23 PM, R8 was lying in bed with the head of bed elevated approximately 30 degrees. R8 was not receiving a bolus feed at that time. R8 showed some signs of muscle wasting on his collar bones and cheeks. R8 was unable to make his needs known verbally but was able and willing to provide a thumb up for a yes and a thumb down for a no. When asked if they provided a bolus feed via syringe through his percutaneous endoscopic gastrostomy (PEG) tube two times that day, the resident gave a thumbs up.

R8's Weights and Vitals Summary dated 3/18/25 shows R8's current weight is 149 pounds (lbs) and was taken on 3/15/25. R8's six-month weight taken on 9/18/24 shows R8 weighed 173 lbs. This is a difference of 24 pounds, or 13.9%.

R8's Nutrition/Dietary Note dated 12/31/24 shows V4 (Registered Dietitian) recommended to increase R8's feeding to a different formula and volume which would provide an additional 90 calories to promote weight gain.

R8's discontinued physician's order report does not show this recommendation was ever updated and R8 continued on the lower calorie formula until 3/7/25, when it was discontinued.

On 3/18/25 at 3:25 PM, V4 stated she has been seeing R8 since R8's admission to the facility. V4 sees R8 at least twice monthly, or more, and

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writes a progress note at least once monthly. V4 is unsure of the accuracy of R8's admission weight and believes R8 to have a more accurate usual body weight around 158 lbs. V4 said even with that information, R8 is down 10 pounds from that, and it is a concern. V4 stated R8 is reliant on his tube feeding for all his nutrition. V4 said she has changed formulas, changed bolus volumes, and has even attempted to provide R8 with a continual tube feeding with no success on preventing V4's weight loss. V4 said all formulations were calculated to provide 100% of R8's daily needs and should have at a minimum provided R8 with weight stability and possibly even gradual weight gain. V4's goal for R8 is for gradual weight gain and to prevent further weight loss.

Facility Weight Monitoring policy dated 10/2024 states, "Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range..."

(B)

Statement of Licensure Violations 2 of 2:

300.610a)
300.3210t)

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

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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 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure a resident that was on an oral anticoagulant medication (blood thinner) was free from physical abuse. This applies to 2 of 3 residents (R12, R13) reviewed for abuse in the sample of 15. This failure resulted in R12 complaining of 5/10 sharp pain to right parietal and temporal area during head examination.

The findings include:

1. The facility's Final Abuse Investigation dated 3/18/25 documents on 3/16/25, (R12) reported that (R13) allegedly hit her on the head.... (R12) reported that she was backing out of the common area with her wheelchair and mistakenly ran into (R13) and (R13) hit her.

R13's face sheet shows R13 is a 57-year-old male with diagnosis including bipolar, paranoid

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schizophrenia, schizoaffective disorder, unspecified mood (affective) disorder, anxiety, disorders of and psychosocial development.

R12's progress notes printed 3/18/25 at 3:16pm in part documents diagnosis of chronic respiratory failure with hypoxia, vitamin deficiency unspecified, obstructive sleep apnea, gastro-esophageal reflux disease without esophagitis, essential hypertension, other chronic pain, obstructive hypertrophic cardiomyopathy, adjustment disorder with mixed anxiety and depressed mood, presence of left artificial hip joint, muscle weakness and chronic obstructive pulmonary disease unspecified.

On 3/18/25 at 9:00 AM, V1 (Administrator) said an allegation of physical abuse was reported on 3/16/25. R12 and R13 were in the dining room, R12 was backing up in her wheelchair and bumped into R13. V1 confirmed R13 hit on R12 the head.

On 3/18/25 at 9:27 AM, R12 was in her room lying in her bed. She said, "Oh there was an incident." She was in the dining room during the noon meal on 3/16/25. She said she was backing up from her wheelchair and accidentally bumped into R13. R13 who gets easily angered punched me on the right side of my head with a closed fist several times. "I've heard of him hitting others and I don't know why they don't do something. He clobbered me and he's a hazard." She said there was no staff in the dining room at the time and R15 witnessed what happened. An egg size bump to the back right side of R13's head was palpated. R13 said "it's sore" and it hurt. She said she doesn't think R13 belongs in this facility, he's not right. They used to have someone with him all the time, "I don't know what happened to

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that." Sometimes we are understaffed.

On 3/18/25 at 11:33 AM, R13 was observed self-propelling himself in his wheelchair in the hallways. He was disheveled, unkempt, with a strong body odor. He was alert to self and unable to answer questions appropriately.

On 3/18/25 at 1:24 PM, R15 said she was in the dining room on 3/16/25. They were at the table finishing lunch, R13 was trying to pass R12. He was ramming his wheelchair into her wheelchair. R12 said give me a minute and R13 started ramming his wheelchair harder into R12. R12 was backing up in her wheelchair and accidentally bumped into R13. R13 stood up from his wheelchair and hit her on the head with his fist several times. He was going to swing another time and he fell back into his wheelchair. He then left the dining room. There was no staff in the dining room at the time, they were taking residents back to their rooms after lunch.

On 3/18/25 at 12:13 PM, V5 (Social Services) said R13 hit R12 in the head while in the dining room on 3/16/25. R13 could not recall the incident. Hitting another resident is physical abuse.

V12's (Nurse Practitioner) progress note dated 3/17/25 documents in part (R12) is alert and oriented, per nursing request (to see resident) after another resident hit (R12) in the head on 3/16/25. (R12) reports backing up her wheelchair and accidently into another resident. (R12) stated, "he hit me in the head several times." "Bleeding precautions from OAC (oral anticoagulant)." "C/o (complains of) 5/10 sharp pain to right parietal and temporal area during head examination." "Patient taking Eliquis 5mg po (orally) BID (twice

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a day) and educated on bleeding precautions." "Will order neuro checks q (every) 4 hrs (hours) x 24hrs and will re-evaluate. Will order cold compress 20 minute duration over right parietal/scalp pain q shift and PRN (as needed) until pain resolved." "Anxious while discussing incident on 3/16/25 and in the setting of pain."

The facility's witness statement by V15 (Registered Nurse) on duty and V16 (Certified Nursing Assistant) said they did not witness the incident.

The facility's Abuse Policy reviewed 11/2024 states, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent, abuse, neglect.....abuse means the willful infliction of injury...willful means the individual must have acted deliberately....physical abuse includes but not limited to hitting, slapping, punching, biting, and kicking..."

(B)