STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007504	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLIGHT HEALTHCARE OF MORRISON	500 NORTH JACKSON STREET MORRISON, IL 61270

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S 000	Initial Comments Annual Licensure Survey First Probationary Licensure Survey-Change of Ownership	S 000		
S9999	Final Observations Statment of Licensure Violations: 300.610a) 300.1210b) 300.1210d)2) 300.1210d)5) 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	S9999		

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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:

2) All treatments and procedures shall be administered as ordered by the physician.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements are not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure interventions were placed when a pressure injury was identified and failed to ensure treatments and pressure reducing interventions were in place for 2 of 3 residents (R33, R21) reviewed for pressure in the sample of 12. This failure resulted in R33 sustaining a stage 3 pressure injury to her coccyx.

The findings include:

1. On 3/3/25 at 10:15 AM, R33 was in bed

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sleeping. R33's air mattress was deflated, and R33 was laying on the bed frame. The air mattress controller said "standby." Heel protection boots were observed in R33's wheelchair in the room. At 10:19 AM, V3 Certified Nursing Assistant came into the room and said the air mattress controller was not supposed to say standby. V3 tried to un-plug and re-plug the unit and the mattress did not inflate. V3 looked at the control unit again and discovered the unit was turned off. V3 turned on the unit, and the mattress inflated. V3 said the mattress needs to be turned on in order to relieve pressure and R33 is supposed to have the heel protection boots on when in bed.

On 3/4/25 at 9:46 AM, V2 Director of Nursing said the floor nurses do weekly skin assessments and complete a progress note if there is a skin issue. V2 said the nurses are supposed to do an assessment with measurements, get treatment orders, and alert her if there is a wound. V2 said she checks the documented measurements and makes sure the doctor is contacted for treatment orders. V2 said, if necessary, the wound doctor can see them.

R33's Skin/Wound Note dated 2/17/25 at 10:45 PM shows, "Resident had shower this evening. Bilateral lower and upper (BL/UL) discolorations. Open sore on coccyx."

R33's Skin/Wound Note dated 2/27/25 at 1:49 PM shows "Pressure wound to sacrum measuring 2.1 x 1.5 x 0.3 cm [centimeters] found during cares. [V6 Wound Physician] in building and saw resident today. Will admit to wound care services. Area cleaned with wound cleanser. New treatment order from [V6] to cleanse wound with wound cleanser. Apply hydrocolloid sheet BID

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S9999	Continued From page 3 [twice per day] and PRN [as needed] for 30 days." On 3/4/25 at 1:52 PM, V2 said R33 has a facility acquired pressure injury. V2 said last Thursday (2/27/25) the Certified Nursing Assistants reported it to her after the wound was found while R33 was being changed. V2 said she looked at the wound and V6 was in the building, so she had him see R33. V2 said she was not aware that it was found on 2/17/25 according to the nurse progress note. V2 said the nurses should have notified her and got treatment orders. V2 said R33 has pressure reducing interventions including an air mattress and cushioned heel boots. V2 said the air mattress should be plugged in and the resident should not be laying on a deflated mattress. V2 said R33 should have her heel boots on when in bed. On 3/5/25 at 10:44 AM, V7 Licensed Practical Nurse said she was in training on 2/17/25 and recalled R33's open area but could not recall details of the wound. V7 said she did not take measurements, get treatment orders, or notify V2. On 3/5/25 at 2:25 PM, V6 Wound Physician said he saw R33 for the first time on 2/27/25 and was told they had found the wound that day. V6 said he classified the wound as a stage 3 pressure injury. V6 said his report shows duration of > (greater than) 3 days, which was based on his clinical judgement of how the wound looked to him. V6 said he saw granulation tissue in the wound and it takes more than 48 hours for granulation tissue to evolve, it doesn't show up right away. V6 said he would expect without treatment, a wound would decline further. V6 said a wound would not improve on its own. V6 said lack of treatment and pressure reducing	S9999		

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interventions would contribute to the wound worsening.

R33's Most recent Braden Scale for Predicting Pressure Ulcer Risk (provided by the facility) dated 7/27/24 shows R33 is at high risk for pressure injury.

R33's Initial Wound Evaluation and Management Summary by V6 is dated 2/27/25 and shows, "Stage 3 Pressure Wound Sacrum Full Thickness, duration: >3 days, measuring 2.1 x 1.5 x 0.3 cm. Recommendations off-load wound, reposition per facility protocol, group 2 mattress."

R33's Physician Orders for February 2025 do not contain wound treatment orders or pressure relieving interventions for R33's coccyx wound until 2/27/25. R33's treatment order were started on 2/27/25 and show, "air mattress to bed for proper weight distribution, check every shift and PRN for proper inflation."

2. R21's Wound Evaluation & Management Summary dated 1/23/25 shows R21 has a stage 2 pressure wound of her left, medial buttock (Site 10) with a duration greater than three days measuring 3.6 centimeters (cm) by 1.9 cm by 0.1 cm and is to receive wound treatment three times a week for 30 days.

R21's Wound Evaluation & Management Summary dated 1/30/25 shows R21's Stage 2 pressure wound (Site 10) had increased in severity to a stage 3 pressure wound measuring 11.2 cm by 6.7 cm by 0.2 cm. R21's Treatment Administration Record (TAR) for 1/1/25 through 1/31/25 does not show any treatment scheduled for R21's pressure ulcer of her left, medial buttock.

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S9999	Continued From page 5 R21's current Order Summary Report for 1/20/25 through 3/31/25 and Order Summary Report for 1/20/25 through 3/31/25 for discontinued orders both show there are no orders for wound treatment of R21's pressure ulcer of her left, medial buttock from 1/23/25 through 2/5/25. On 3/4/25 at 1:52 PM, V2, Director of Nursing and Wound Care Nurse, said R21's pressure ulcer of her left medial buttock was identified when she was doing wound rounds with the Wound Care Physician, V6. On 3/5/25 at 10:19 AM, V2 said V6 does his progress notes of each resident wound right away after his wound rounds on Thursdays. V2 said she accesses V6's progress notes (Wound Evaluation & Manage Summary) and enters his treatment orders into their computer system and treatment orders are started the next day. On 3/5/25 at 2:22 PM, V6 said he would expect a wound to worsen/decline if wound treatment is not being provided. The facility's Assessment of Skin Alteration Policy dated 11/2017 shows residents with skin alteration will be assessed and treatment will be provided as ordered by the physician. (B)	S9999		