STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOWBER.	A. BUILDING:		COM	COMPLETED	
		IL6001663	B. WING		C <b>05/09/2014</b>		
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE			
DICHI A	ND HEALTH CARE CE	1450 26T	H STREET				
HIGHLAI	ND REALIN CARE CE	HIGHLAN	ND, IL 62249				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
S9999	Final Observations		S9999				
	Statement of Licens	sure Violations	отпользований продуктивной продуктивном продуктивном продуктивном продуктивном продуктивном продуктивном продуктивном продуктивном прод				
	300.610a) 300.1210b) 300.1210d)6) 300.3240a)						
	a) The facility shall procedures governifacility. The written be formulated by a Committee consisting administrator, the amedical advisory conformer of nursing and othe policies shall complete written policies the facility and shall by this committee, cand dated minutes of the facility and shall by this committee, cand dated minutes of the facility and shall by this committee, cand dated minutes of the facility and shall by this committee, cand dated minutes of the facility and shall by this committee, cand dated minutes of the facility and shall be accordingly to the facility and shall be accordingly to the facility and shall be accordingly to the facility and shall be accordingly the facility and shall be accordingly the facility and shall be accordingly to the facili	dvisory physician or the ommittee, and representatives in services in the facility. The y with the Act and this Part. shall be followed in operating the reviewed at least annually documented by written, signed of the meeting.					
	Nursing and Person b) The facility shall pand services to atta practicable physical well-being of the reseach resident's complan. Adequate and care and personal cresident to meet the care needs of the reshall include, at a mprocedures:  d) Pursuant to subscare shall include, a and shall be practiced.	provide the necessary care in or maintain the highest , mental, and psychological sident, in accordance with a prehensive resident care properly supervised nursing eare shall be provided to each e total nursing and personal esident. Restorative measures inimum, the following ection (a), general nursing at a minimum, the following ed on a 24-hour,					
	seven-day-a-week b	pasis:	0 100000		:		
Ilinois Depart	ment of Public Health						

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

TITLE

(X6) DATE

BLAR11

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	b:	СОМ	PLETED	
		IL6001663	B. WING		C 05/09/2014		
					1 00,	03/2014	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
HIGHLA	ND HEALTH CARE CE	ENIER	H STREET ID, IL  62249	)			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	T	PROVIDER'S PLAN OF CO	PRECTION	(VE)	
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 1	S9999				
	6) All nacessan	correcutions shall be taken to					
		y precautions shall be taken to dents' environment remains	TANKAN PARAMAN			The system of th	
		hazards as possible. All				***************************************	
		shall evaluate residents to see	The second secon				
		eceives adequate supervision					
	and assistance to p		- Constitution				
			OP-MA Adversaria				
	C - : 11 - : 000 0040 A		Common Annual An				
	Section 300.3240 A		definition are property				
		ee, administrator, employee or nall not abuse or neglect a	Edition in the second				
	resident	all hot abuse of neglect a	A CONTRACTOR OF THE CONTRACTOR				
	TOSIGOTI		no-haddelphiliphidolyw				
	These requirements	s were not met as evidenced	A CONTRACTOR OF THE PROPERTY O				
	by:						
			vand-dygggydd.				
	D. and an internal	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
		and record review the facility					
		f was aware of their scope of for one of three residents (R1)	Note the second	TO COMMANDA		WWW.Workships	
		its/ occurrences in the sample					
V V V V V V V V V V V V V V V V V V V		ulted in R1 incurring a burn					
		surring pain to the right hip.					
						100000000000000000000000000000000000000	
	Findings include:	The state of the s					
With the same of t	WRITTEN REPORT	F/RESIDENT OCCURRENCE					
		ents at approximately 1:40pm				Annual de la	
		nsed Nurse entered R1's					
PPOPUPOLIA		treatment and noted an area					
	of redness with a flu	id filled blister to R1's right					
	hip. E2, Certified Nu	rse Aid, CNA, was in the				Hill-falcons are	
		the nurse that she had					
		o the resident earlier that day,					
		to R1 complaining of right				10 (10 (10 (10 (10 (10 (10 (10 (10 (10 (	
		therapy department and got					
		Therapist, instructions on					
		with protective covers and					
	she then placed it to						
***	approximately 30 mi	nutes. R1 presented with a					

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED  C 05/09/2014	
		IL6001663	B. WING		1		
	PROVIDER OR SUPPLIER	ENTER 1450 267	DDRESS, CITY, S TH STREET ND, IL 62249	TATE, ZIP CODE			
(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 AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
\$9999	19 centimeter (cm) her right hip, with a towards the middle Basic first aid was on 5/8/14 at 1:03pr regarding R1 havin hip. E9 stated she spack but didn't know for lunch. E1 Licens called E9 into R1's been removed and R1 was complaining. Interview on 5/8/14 Therapist, stated Eroom and asked for instructions for pad protection. E2 replied CNA's do come in fit themselves and did them on R1.  Interview on 5/8/14 Rehabilitation Direction the therapy room are own use. E11 stated nothing about any rethe hot pack on.  Interview on 5/8/14 1:03pm with E8 CN 2:20pm with E12 CI CNA all stated hot pany resident by CN/E10 CNA stated hot for the control of	by 13 cm area of redness to 2 cm by 2cm fluid filled blister aspect of the reddened area. provided.  In E9 was interviewed g hot packs applied to the right saw E2 in the hall with a hot w who it was for. E2 then left sed Practical Nurse (LPN) later room after the hot packs had noted burn/blister on right hip. g of pain.  at 10:10am with E3, 2 did come into the therapy r hot packs. E3 gave ding the hot packs for ed she knew. E3 further states for hot packs to use on I not know E1 was going to put					
		pecialized Wound Nurse what it should, dark area will					

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION :	(X3) DATE	SURVEY
, , , ,			A. BUILDING		C	
IL6001663		B. WING		1	)9/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HIGHLA	ND HEALTH CARE CE	:NIER	1 STREET D, IL 62249			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	D, IL 02249	PROVIDER'S PLAN OF CORRECTION		(VE)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From page 3		S9999			
	slough off, area without infection and treatment appropriate.					
	Interview with Z2, on 5/9/14 at 9:50AM by telephone, Nurse Practitioner (NP) stated surround discolored tissue is a concern, uncertain what will become of it.					
	(DON) removed the and a foul odor was hip was the size of a area with yellowish superficial open are surrounding area of	n with E5 Director of Nursing dressing on R1's right hip noted. The area on the right a golf ball and the brown/black is slough. Above that was 2 as about dime size. The the right hip had about 4.5 e tinge E5 stated R1's right not pack incident.				
	documented on 4/30 complained of right pack on R1's right h 11:00am. No redne R1's room to do trea and noted burn 19 c 2cm by 2cm blister t	ESS NOTE & CARE PLAN 0/14 at 1:40pm R1 hip pain. CNA placed hot ip. and removed it at ss or blister noted. E1 went to atments E1 pulled cover back (m(centimeter) by 13cm and to right hip. R1 complained of ctor was informed and				
	5/1/14 documents W	ed Wound Nurse form dated Jound Type/Grade Burn/ 2nd Length 16cm by 13cm. Area				
	documents length 15	Management dated 5/8/14 5cm by 13cm and unable to ea 195cm. Center of wound cm necrosis.				

Illinois Department of Public Health

Review of Z2's visit dated May 7, 2014

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:	OMPLETED	
	C 05/09/2014	
IL6001663 B. WING		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
1450 26TH STREET		
HIGHLAND HEALTH CARE CENTER HIGHLAND, IL 62249		
(X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S9999  Continued From page 4 documents patient is under weight and frail. Right trochanter area caused by burn on the trochanter 4cm by 3cm blister denuded. Surrounding itsue has discoloration variegated purplish colored area below the surface of the skin. R1 is uncomfortable and has history or joint pain from arthritis and contractures of joints.  Policy: Compresses, Clean-Warm (General Guidelines) policy dated 2006 documents BASIC RESPONSIBILITY; Licensed Nurse. PROCEDURE. Check physician's order.  (B)		

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