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	IL6009542	A. BUILDING: _____ B. WING _____	03/20/2024

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S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations (1 of 2) 300.610a) 300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.2090b) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a	S9999		

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comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

c) Each direct care-giving staff shall review and 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.

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Section 300.2090 Food Preparation and Service

b) Foods shall be attractively served at the proper temperatures and in a form to meet individual needs.

These Requirements were not met evidenced by:

Based on observation, interview, and record review the facility failed to ensure residents were served food at a safe temperature. This failure resulted in R273 spilling hot soup and receiving full thickness burns on his right forearm and abdomen. The facility failed to safely transfer residents with a mechanical lift. The facility failed to ensure medications were stored in a safe manner away from a cognitively impaired resident. The facility also failed to ensure residents at risk for choking were supervised during meal times and provided thickened liquids as prescribed. This applies to 6 of 18 residents (R17, R9, R51, R52, R53 & R273) reviewed for safety and supervision in the sample of 18.

The findings include:

1. On 3/19/24 at 11:46 AM, the soup on the second floor was measuring 181.7 degrees Fahrenheit (F).

R52's facility event report dated 6/5/23 shows, "Hot soup during lunch was spilled on resident's right hand and leg."

R52's progress note dated 6/5/23 shows, "During lunch time resident was served hot soup. Bowl slipped from universal worker's hand and was spilled on resident's right hand and lap ..."

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V4 Dietary Manager's statement for R52's event shows, he saw V5 Resident Aide (universal worker) trip and spill hot soup on R52. He heard R52 "yell that she was "burning and hot"." On 3/20/24, V4 Dietary Manager confirmed his statement.

On 3/20/24 at 9:01 AM, R52 stated, she remembered when soup was spilled on her. She didn't know what happened but that hot soup was spilled on her. "It was very hot. I cried a lot because it hurt." She also stated, you have to let the soup sit and cool down because it is "boiling hot" before you can eat it.

R52's minimum data set dated 12/18/23 shows, she is cognitively intact.

On 3/19/24 at 1:05 PM, V4 Dietary Manager stated, they have not done anything different after R52 had hot soup spilled on her. The minimum temperature of the soup is kept at least 165 degrees F.

R273's facility event report dated 11/6/23 shows, "spilled hot soup during lunch on right arm."

R273's progress notes dated 11/6/23 at 1:04 PM shows, "Resident continues to refuse to get up from the bed to his wheelchair for meals. During lunch time he spilled hot soup on his right arm. Arm painful and red ..." The same progress notes at 11:48 PM shows, "Received report about resident soup incident ... Observed a blister on resident right side of the abdomen."

R273's progress notes dated 11/7/23 at 2:35 PM shows, "Observed fluid filled blister on the anterior of the right upper arm and open area approximate 7 cm (centimeter) x 5.5 cm partial

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thickness. Resident c/o (complain of) pain on the site ..."

R273's wound doctor evaluation and management summary dated 11/13/23 shows, he has a full thickness burn wound of the right, upper, medial arm measuring 5.0 x 7.1 x 0.1 cm (length x width x depth). "Additional wound detail: Area of partial, deep-partial and likely some full thickness thermal burn from where pt (patient) spilled coffee on himself." There is nothing documented about the burn on his abdomen.

R273's wound doctor evaluation and management summary dated 11/20/23 shows, he has a full thickness burn wound of the right, upper, medial arm measuring 5.0 x 5.1 x 0.1 cm and a full thickness burn wound of the right, lower abdomen measuring 4.1 x 1.3 x 0.1 cm.

On 3/20/24 at 10:49 AM, V6 Wound Care Nurse stated, R273 had between 2nd and 3rd degree burns on his forearm and abdomen.

On 3/20/24 at 6:05 PM, V37 Advanced Practice Registered Nurse (APRN) stated, she was aware of R237 spilling hot soup on himself and obtaining full thickness burns to his right arm and abdomen. The expectation would be not to serve soup that is too hot for residents to eat. 185 degree F soup is too hot to serve to residents.

On 3/19/24 at 1:19 PM, V4 stated, he did not have temperature logs for the soup. They are taking the temperatures of the soup but not logging them.

The facility did not provide any food temperature logs for the soup.

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The facility's food temperatures policy dated 2017 shows, "Policy: The temperatures of all food items will be taken and properly recorded prior to service of each meal. Procedure: 1. b. Hot food items may not fall below 135 degrees F after cooking, unless it is an item which is to be rapidly cooled to below 41 degrees F and reheated to at least 165 degrees F prior to serving. Caution should be taken to avoid serving food and liquids at temperatures that are too hot to avoid the risk of burns."

2. R273's facility event report dated 9/20/23 shows, "Two CNA's (V38 & V39 Certified Nursing Assistants) had pt (patient) on the [mechanical lift] and bumped his head creating two skin tears on top of cranium ... Measurement of Injury: 1.8 x 1.3 cm and 1x1 cm. Evaluation: ON 9/20/23, resident was being transferred in [mechanical lift] and upon being lowered into chair, resident hit his head against pad on the lift and two skin tears were obtained ... Nurse did immediate re-education with two CNAs on how to lower lift without bumping chair."

On 3/20/24 at 9:15 AM, V39 CNA stated, V38 and her were transferring R273 from his bed to the wheelchair when he bumped his head on the mechanical lift. He hit his head on the cross bar of the mechanical lift. R273 had 2 open areas on the top of his head.

The facility's transfer and positioning policy dated 5/2017 shows, "6. EZ lift (mechanical lift)- when someone is an EZ lift that means they cannot bear weight and are totally dependent for transfers ... The most important thing to remember with the EZ lift is that the bars spin sideways and back and forth as well as around, so use extreme caution when moving the lift

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around the resident ...

3. On 03/19/24 at 09:24 AM V27, R17's daughter, said she was not happy because her mom, R17, got hit with a (mechanical) lift. V27 said she was called and informed R17 had a mark under her eye from the incident on a Tuesday (1/8/24) and when she arrived to the facility on Saturday (1/13/24) to visit R17, R17 had a huge black eye. V27 said she worried R17's facial bone could be fractured and asked for an x-ray to be done. V27 said during this visit with R17 (on 1/13/24) R17 wanted to go back to bed. V27 said when the CNAs came in to transfer R17 to bed, they were not watching what they were doing and they hit R17 with the main bar of the lift again.

On 3/18/24 at 2:22 PM, V21, CNA, said she along with another CNA were transferring R17 with the full mechanical lift (on 1/8/24). V21 said the footrest of R17's wheelchair got caught on the leg of the mechanical lift, so when the lift was lowered, the wheelchair came down fast and R17 came forward and bumped her head on the lift. V21 said, "That was my error." V21 said R17 did bruise up and have swelling, but she did not go to the hospital.

On 3/20/24 at 10:41 AM, V22, CNA, said she was one of the CNAs assisting R17 to transfer from her wheelchair to her bed (on 1/13/24) with the mechanical lift. V22 said they began moving the lift toward R17's wheelchair and did it "slightly too quickly; we definitely could have done it a little slower" and they bumped R17's head with the scale box on the lift. V22 said "it was definitely user error on our part."

On 3/20/24 at 11:20 AM, V30, CNA, said she was assisting to help transfer R17 from her wheelchair

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to bed with the mechanical lift (on 1/13/24). V30 said they were getting R17 hooked up to the lift and were trying to maneuver it and "I guess we were not careful enough and not watching" and we bumped R17's head with the weight box on the lift.

R17's Minimum Data Set (MDS) dated 2/28/24 shows she has severe cognitive impairment. R17's current Care Plan (edited 3/20/24) shows R17 sustained a bruise to her face below her left eye measuring 5 cm (centimeters) by 2 cm due to an incident with a mechanical lift of 1/8/24. The same care plan shows R17 was bumped on her forehead with a mechanical lift machine when staff were giving care. The same care plan shows R17 requires extensive assistance with ADLs (activities of daily living) and two staff member for transfers with a mechanical lift.

4. On 3/19/2024 at 11:45AM, V17 Home Health Aide said she was transferring R48 with the assistance of V14 - Certified Nursing Assistant. V17 said the mechanical lift started to tip and R48 bumped her head on the lift, no bleeding or bruising noted.

On 3/19/2024 at 1:40PM, V14 said he was helping V17 with a full mechanical transfer and the lift started to tip and R48 bumped her head on the cross bar of the lift, no bleeding or bruising noted at that time.

On 3/19/2024 at 12:27PM, V7 Licensed Practical Nurse (LPN)/ Rehab Coordinator said if the lift is used correctly, it should not tip over or start to tip over.

R48's Care Plan, revised on 1/23/2024 states . . . At this time R48 needs max asst with adl's

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(activities of daily living). Transfers with total mechanical, w/c pushed by staff, and ambulation is not feasible at this time. . .

5. R9's Speech Therapy Evaluation and Plan of Treatment dated 3/15/24 states, "Patient referred to SLP (speech language pathologist) due to new onset of signs/symptoms of dysphagia and risk for aspiration causing change in swallowing abilities related to dementia... Self Feeding = Patient requires assistance, to address in treatment plan..."

R9's Physician's Orders form (no date) shows R9's Dietary Order is general, honey thick, mechanical soft. R9's Dietary Order states, "Needs 1:1 (one-to-one). Alternate solids/liquids. Small bites/drinks. No straws. Upright 90 degrees. Multiple swallows."

On 3/19/24 at 8:37 AM, R9 was lying in bed with the head of the bed elevated approximately 45 degrees. On R9's bedside table, within R9's reach, was a breakfast tray with a half full bowl of cereal with thin 1% milk in it, a half full carton of thin 1% milk, and a half full cup of thin apple juice. Staff was not present.

On 3/19/24 at 12:40 PM, the first floor kitchenette did not have any honey thickened milk but it did have honey thick juice and honey thick water.

On 3/19/24 at 12:43 PM, V4 (Dietary Manager) showed this surveyor a full case of honey thick milk in the dry storage area in the main kitchen. V4 said even if staff run out of honey thick milk at the point of service, staff know to run to the kitchen and grab what is needed. V4 also said that there are thickening packets available in each kitchenette if staff need to thicken

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beverages at the point of service.

On 3/19/24 at 11:44 AM, V4 said any resident ordered to receive honey thick liquids should never receive thin apple juice or thin 1% milk. If served thin liquids, their risk for aspiration, choking, or food in lungs can increase. V4 also said that a certified nursing assistant (CNA) should never leave that room if they require one-to-one assistance with meals. The tray should have been picked up and removed after finishing assisting R9 with feeding. There should be no food or drink in front of them and left with them if they are one-to-one and no staff are present.

Facility Dining Room Seating, Swallow Protocol and Supervision Policy dated 2/2023 states, "... Residents identified as 1:1 or close supervision cannot eat or drink in their rooms without a refusal of treatment. Swallow Precaution Status Definitions: 1:1- CPR certified CNA or nurse sitting at the table that only focuses on one resident. Staff member cannot leave the table while the resident is eating. No food or drinks set at the table until the designated staff member serves the resident's tray."

6. R59's Event Report dated 2/28/24 states, "Resident is impulsive, forgetful, confused d/t (due to) UTI (urinary tract infection), just returned from hospital yesterday."

On 3/20/24 at 4:01 PM, V11 (LPN) said on 2/27/24 at approximately 9:15 AM, V11 prepared a small plastic pill cup (2 tablespoons in volume) with approximately one-half tablespoon of calmoseptine cream. After dispensing the cream into the pill cup, V11 went into R59's room and placed the cup down, waiting for R59 to return

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from breakfast. The pill cup with the cream in it was left unattended in R59's room. While waiting for R59 to return to the room, V11 was called to two different rooms back to back to send two residents out to the local hospital to receive emergency care. When V11 returned to R59's room, R59 was already taken for therapy.

On 3/19/24 at 1:54 PM, V19 (Occupational Therapist) said on 2/27/24 at approximately 9:00 AM, V19 went to R59's room to get her ready for therapy. R59 was found in her wheelchair and V19 noticed something white on R59's lips and inside of R59's mouth. V19 asked R59 if she had taken her medicine and R59 could not recollect. V19 then called the unit secretary to let them know about the incident and the unit secretary informed the unit nurse. V18 (CNA) then came to the therapy room and returned R59 to R59's room.

On 3/19/24 at 11:33 AM, V18 said on 2/27/24 at approximately 9:45 AM, V18 used a washcloth with warm water and a sponge to rinse out R59's mouth to remove the remaining cream. V18 said V59 had a pinkish white film coated on R59's teeth and all inside of R59's mouth.

On 3/20/24 at 4:01 PM, V11 said after realizing that R59 had potentially ingested the cream that was left in R59's room, V11 went into R59's room and found the plastic pill cup of cream in R59's trash can. The cup looked as if a finger was used to scoop out the cream. V11 said R59 was recently placed on an antibiotic for a new diagnosis of a urinary tract infection. Due to the infection, V11 said that R59 was more confused and forgetful compared to R59's baseline. V11 called poison control with V15 (RN) and poison control said to monitor R59 for nausea, vomiting,

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and diarrhea. V11 said R59 did not experience any nausea, vomiting, or diarrhea throughout the rest of V11's shift. V11 said the cup with cream should not have been left in R59's room unattended.

On 3/19/24 at 1:27 PM, V2 (Director of Nursing) said that ointments or treatments for confused residents shouldn't be left unattended. It is recommended that the task is completed while you are in there with the resident.

(B)

Statement of Licensure Violations (2 of 2)

300.661

Section 300.661 Health Care Worker Background Check

A facility shall comply with the Health Care Worker Background Check Act and the Health Care Worker Background Check Code.

This requirement was NOT met as evidenced by:

Based on interview and record review the facility failed to initiate Internet website background checks, including the Illinois Sex Offender Registry, Department of Corrections' Sex Offender Search Engine, Department of Corrections' Inmate Search Engine, Department of Corrections Wanted Fugitives Search Engine, National Sex Offender Public Registry, and Health and Human Services Office of Inspector General Registry, prior to hiring new employees

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for 6 of 10 employees (V31-V36) reviewed for healthcare worker background checks.

This failure has the potential to affect all 77 residents in the facility.

The findings include:

The facility's Long-Term Care Facility Application for Medicare and Medicaid form dated 3/18/24 showed a resident census of 77.

A facility employee list dated 3/18/24 showed V31 Certified Nursing Assistant (CNA) was hired on 2/5/24. V31's employee records showed all of V31's website background checks were not completed until 2/9/24.

A facility employee list dated 3/18/24 showed V32 Laundry Aide was hired on 10/16/23. V32's employee records showed all of V32's website background checks were not completed until 10/26/23.

A facility employee list dated 3/18/24 showed V33 CNA was hired on 11/30/23. V33's employee records showed all of V33's website background checks were not completed until 12/4/23.

A facility employee list dated 3/18/24 showed V34 Housekeeping was hired on 8/14/23. V34's employee records showed all of V34's website background checks were not completed until 8/15/13.

A facility employee list dated 3/18/24 showed V35 CNA was hired on 11/13/23. V35's employee records showed all of V35's website background checks were not completed until 11/15/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009542	A. BUILDING: _____ B. WING _____	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY HI NURSING HOME	2406 HARTLAND ROAD 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 A facility employee list dated 3/18/24 showed V36 CNA was hired on 2/5/24. V36's employee records showed all of V36's website background checks were not completed until 2/9/24. On 3/19/24 at 10:13 AM, V13 Employee Coordinator stated she was responsible for completing all background checks on new employees. V13 stated, "I thought all the website checks didn't need to be done until just prior to the employee hitting the floor (providing patient care)." V13 stated she did not know that employee website background checks had to be done prior to hiring an employee. The facility's Employee Background Check Policy dated 10/2016 showed the facility "must also conduct further background checking of candidates before hiring. The registries are as follows: Illinois Sex Offender Registry, Department of Corrections' Sex Offender Search Engine, Department of Corrections' Inmate Search Engine, Department of Corrections Wanted Fugitives Search Engine, National Sex Offender Public Registry, and Health and Human Services Office of Inspector General ..." (C)	S9999		