STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145222	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlight Hlthcr of Woodstock	309 McHenry Avenue Woodstock, IL 60098

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40798 Based on observation, interview and record review, the facility failed to ensure hot liquids are served in a safe manner and failed to ensure 1 of 7 residents (R1) in the sample of 7 reviewed for safety and supervision was supervised and assisted while drinking hot coffee. These failures resulted in R1 spilling coffee on herself and sustaining second degree burns to her thighs. The findings include: The Facility Data Sheet dated 2/5/25 shows the facility has 76 residents in residing in the facility. On 2/5/25 at 9:24 AM, R1 said she was drinking coffee out of a Styrofoam cup and somehow the coffee got out of her hand and spilled on her upper thighs and it was really hot. R1 said no one (staff) was in the dining room and she yelled for help. R1 said someone eventually came and a nurse looked at her thighs. R1 said she was sent to the hospital and returned later the same day. R1 said she has been receiving treatment to her burns every day since then. On 2/5/25 at 10:56 AM, R3 said he was in the dining room at dinner time with a lot of other residents when R1 began screaming for help in the dining room. R3 said R1 was saying help, help, I spilled my coffee. R3 said there was no staff in the dining room at the time. On 2/5/25 at 10:30 AM, V4, Certified Nursing Assistant (CNA), said she was outside of the dining room (around 5:00 PM on Sunday, 2/2/25) and heard R1 screaming. V4 said R1 told her she spilled her coffee. V4 said a staff member is supposed to be in the dining room at all times for resident supervision. V4 said no one is specifically assigned to supervise the dining room. V4 said staff know what level of care a resident requires (whether they are independent, dependent, require a mechanical lift, require assistance eating, etc.) from a verbal report from other staff members or from a cheat sheet they compile. On 2/5/25 at 11:15 AM, V3, Registered Nurse (RN), said around supper time on 2/2/25, V4 was outside of the dining room and heard R1 yelling. R1 was visibly in pain and V4 found V3 to go to R1. V3 said he visually assessed R1 and R1 allowed him to touch her clothed legs which were warm to his touch. V3 said a staff member is supposed to be in the dining room at all times during meals for safety. V3 said R1 requires full care and is dependent on staff for her ADLs (activities of daily living). V3 said the level of care a resident requires is available in the resident's care plan. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145222	A. Building B. Wing	02/13/2025

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Highlight Hlthcr of Woodstock	309 McHenry Avenue Woodstock, IL 60098

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/5/25 at 10:09 AM, V5, (RN), said staff try to be in the dining room when residents are eating meals, but it might not always happen. V5 said it would be hard to say there is someone always supervising the dining room (during meals). On 2/5/25 at 11:43 AM, V5 said she was asked to assess R1 (on 2/2/25) because she can have female caregivers only. V5 said R1's skin was red and warm to the touch from her mid thighs to her groin. V5 said R1 told her it was extremely painful and wanted to call 911. V5 said she spoke to the doctor, and they agreed to send R1 to the hospital. V5 said when she returned to R1 to apply a cool compress, she noticed a blister forming on R1's left inner thigh. V5 said the Care Plan would show what level of care residents need. On 2/5/25 at 1:00 PM, V2, (Director of Nursing), said she received a call from V3 on Sunday, 2/2/25 around 5:30 PM reporting that R1 had spilled hot coffee on her thigh and groin area. V2 said R1 was sent to the hospital and returned later that evening with orders for twice a day burn treatment for the second degree burns she sustained to her groin, thighs, lap. V2 said staff are to supervise the dining room during meals for resident safety. V2 said the level of care a resident requires is available in the resident's care plan. On 2/10/25 at 10:50 AM, V8, (Dietary Manager), said all staff know the temperature of coffee and hot water needs to be 140 degrees F (Fahrenheit) prior to serving it to the residents. V8 said it (coffee/hot water) can be a degree or two below 140 degrees F, but not any hotter. V8 said no hot liquid temperatures above 140 degrees F are acceptable; someone could accidentally spill and burn themselves. Anything greater than 140 degrees F is just too hot for safety. On 2/10/25 at 8:57 AM, V10, (Dietary Aid), said they are supposed to check the coffee and hot water temperature before taking coffee to the dining rooms. V10 said the temperature should be between 138 and 140 degrees F, but she is confused because she was also told it could be around 150 degrees F. On 2/10/25 at 10:10 AM, V10 said the coffee and the hot water currently on the cart is the remaining coffee and hot water served at breakfast this morning. On 2/10/25 at 9:43 AM, V11, (Dietary Aid), said they are supposed to check the coffee and hot water temperatures before going out to the residents. V11 said the temperature should be 165 degrees F. On 2/10/25 at 9:54 AM, V12, (Cook), said he thinks the coffee should be between 145- and 165-degrees F at a minimum. V12 said he thinks burns can happen at 125 degrees F. V12 said the residents would be closely monitored if they are not cognitively capable of handling hot coffee. V12 said he does not know if the coffee temperature is checked before going out to the residents. V12 said he does not know when the coffee and hot water (currently on the cart) was prepared, but assumes it was around 6:00 AM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/10/25 at 10:30 AM, V13, (Dietary Aid), said she made the coffee for breakfast today at around 6:50 AM. V13 said the coffee and hot water should be between 145- and 150-degrees F before going out to the residents. V13 confirmed the coffee and hot water currently in the dispensers on the cart are the same coffee and hot water she prepared prior to breakfast the morning. V13 checked the temperature of the coffee and hot water currently in the dispensers. The hot water was 156 degrees F, dispenser 1 containing coffee was 153 degrees F, and dispenser 2 containing coffee was 122 degrees F. V13 dumped the coffee out of dispenser 2, made fresh coffee, and fully refilled dispenser 2 and topped off dispenser 1 to about half full. On 2/10/25 at 11:13 AM, V13 made fresh coffee and poured it directly into 14 mugs for residents in the big dining room. V13 checked the temperature of coffee in each mug and the temperatures ranged from 146 degrees F to 152 degrees F. V13 put lids on the mugs then checked the temperatures of the coffee in the dispensers. The coffee in dispenser 1 was 149 degrees F and the coffee in dispenser 2 was 154.2 degrees F. V13 did not recheck the hot water temperature. V13 then took the cart with the dispensers of coffee and hot water and mugs of coffee to the big dining room and proceeded to pass the mugs of coffee out to the residents. V13 delivered one mug of the hot water from the dispenser to a resident with a tea bag. On 2/10/25 at 11:44 AM, V10 (Dietary Aide) delivered another cart with three thermal carafes to the small dining room. V10 said she forgot to check the temperature of the coffee and hot water on the cart. When prompted, V10 got a thermometer and the coffee in the two carafes was 151.7 degrees F and 135 degrees F, and the hot water was 145 degrees F. On 2/10/25 at 11:58 AM, staff members were seen dispensing and delivering coffee from both carafes to the residents in the small dining room. R1's Admission Record dated 2/5/25 shows R1 diagnoses include, but are not limited to, hemiplegia and hemiparesis following cerebral infarction (stroke), chronic kidney disease, dysphagia (difficulty swallowing), epilepsy, seizures, reduced mobility, brain tumor, and cognitive communication deficit. R1's current care plan provided by the facility shows R1 has problems with decision-making, insight, logic, calculation, reasoning, planning, and judgement. R1's care plan also shows R1 has an ADL self-care performance deficit and is totally dependent on staff for eating, bathing, bed mobility, dressing, toilet use, and transfers. R1's Minimum Data Set, dated dated dated [DATE] shows R1 has moderate cognitive impairment and requires partial/moderate assistance with eating. R1's After Visit Summary from the hospital dated 2/2/25 shows her diagnosis is second degree burns of multiple sites. R1 was prescribed an oral narcotic for pain and cream to be applied twice a day to her burns. The facility's Hot Liquid Safety Policy (revised 2/2025) shows, .residents with difficulties will receive appropriate supervision .interventions will be individualized and noted on the resident's plan of care . and hot liquids can cause scalding and burns. The temperatures of hot liquids will be checked in the dietary department prior to distribution. If the temperature is greater than 140 degrees F, the liquid will be held in the dietary department until it reaches an appropriate temperature. Limit Styrofoam cups to residents with no difficulties.