

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145706	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Whitehall of Deerfield		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Waukegan Road Deerfield, IL 60015	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>35541</p> <p>Based on the interview and record review, the facility failed to ensure that a resident's caregiver immediately reported a new injury of unknown origin for 1 of 1 residents (R1), who were reviewed for injuries of unknown origin in the sample of 4.</p> <p>The findings include:</p> <p>R1's current care plan showed that R1 was nonverbal, severely cognitively impaired, completely dependent on staff for all care, and unable to move her lower extremities without staff assistance due to her diagnosis of senile degeneration of the brain.</p> <p>A progress note for R1, dated 12/9/24, showed, Writer was notified by caregiver of bruise on left big toe, slightly swollen . Per caregiver, weekend caregiver identified the incident but did not report to the nurse on duty at the time . ordered X-ray of left foot. Site slightly warm to touch, no grimacing or pain elicited upon site palpation .</p> <p>R1's left foot X-ray report dated 12/10/24 showed results of acute intra-articular corner fracture at the lateral margin of the left great toe .</p> <p>R1's bruise/injury of unknown origin report showed R1 was unable to state what happened to her left toe due to her poor cognition. The report showed R1's power of attorney elected to not send R1 to the hospital for the injury but to have R1 remain in the facility and follow-up with R1's podiatrist.</p> <p>On 12/18/24 at 9:09 AM, R1 was seated in a wheelchair in her room as V3 (agency caregiver) fed R1 breakfast. This surveyor attempted to ask R1 questions but received no verbal response from R1. No spontaneous movement of R1's upper or lower extremities was noted. V3 stated R1 has a caregiver, hired by R1's family, assigned to her 7 days a week, from 8 AM-4 PM. V3 stated caregivers help facility staff provide cares to R1 but their role is primarily to provide companionship to R1 in the facility. V3 stated she alerted facility staff to R1's left toe injury on 12/9/24 as she found R1's great toe to be bruised and swollen. V3 stated, Her weekend caregiver (V18) actually noticed the bruising the day before (12/8/24) but I guess didn't tell any staff (facility) . V3 removed R1's sock on her left foot. Old, faded bruising was noted to the area between R1's left great toe and second toe. No redness, swelling, or wounds were noted to R1's left foot.</p> <p>(continued on next page)</p>

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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/18/24 at 1:38 PM, V18 (agency caregiver) stated she was assigned to R1 on 12/8/24, from 8 AM-4 PM V18 stated when she got R1 dressed that morning, she noticed R1's left great toe was bruised and swollen. V18 stated she never reported her findings to any facility staff on 12/8/24. V18 also stated she did not report R1's toe injury to her staffing agency until 12/9/24. V18 stated, I should have reported it immediately. I just assumed everyone knew about it .</p> <p>On 12/18/24 at 11:53 AM, V1 (Administrator) stated any resident caregiver, hired by a family to provide services to residents in the facility, are held to the same standards and expectations as our employees. V1 stated, We treat them (caregivers) as our employees. We do background checks on them as soon as we know they are going to be with our residents. Our concierge then reviews the private duty guidelines packet with the caregiver which the caregiver signs. In the packet, it specifically says the caregiver will follow the same rules as our staff which includes reporting abuse and/or injuries of unknown origin. (V3 agency caregiver for R1) reported (R1's) injury to us on that Monday (12/9/24). V18 (agency caregiver for R1) should have reported (R1's) injury immediately to a nurse when she found it on that Sunday (12/8/24) .</p> <p>On 12/18/24 at 2:00 PM, V2 (Director of Nursing) stated any resident caregivers that provide services in the facility are expected to follow the facility's abuse policy and report injuries of unknown origin immediately to a facility nurse.</p> <p>On 12/18/24 at 12:09 PM, V6 (Agency Supervisor of V18) stated V18 (agency caregiver of R1) should have reported R1's injury to the facility and the agency immediately on 12/8/24.</p> <p>The facility's Private Duty Guidelines orientation packet (undated) showed, While the patient is under our care it is your responsibility to cooperate fully with the policies and guidelines of this facility to maintain our high standards of care .Private duty personnel will follow the same rules of (facility) that all staff is required to follow . All accidents, loss of personal property or irregular occurrences must be reported to the charge nurse immediately . A change in the resident's condition should be immediately reported to the charge nurse .</p> <p>The facility's Abuse and Neglect policy dated 7/12/24 showed, Injuries of Unknown Origin are injuries that meets all 3 criteria . a) The source of the injury was not observed by any person; and b) The source of the injury could not be explained by the resident; and c) The injury is suspicious because of the extent of the injury or the location of the injury . All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>35541</p> <p>Based on interview and record review the facility failed to provide cares to a resident in manner that prevented a resident injury. The facility failed to ensure a resident was transferred via mechanical lift in a safe manner. These failures apply to 1 of 4 residents reviewed for safety and supervision in the sample of 4.</p> <p>The findings include:</p> <p>R1's current care plan showed R1 was nonverbal, severely cognitively impaired, completely dependent on staff for all cares, and unable to move her lower extremities without staff assistance due to her diagnosis of senile degeneration of the brain.</p> <p>A progress note for R1, dated 12/9/24, showed, Writer was notified by caregiver of bruise on left big toe, slightly swollen . ordered X-ray of left foot. Site slightly warm to touch, no grimacing or pain elicited upon site palpation .</p> <p>R1's left foot X-ray report dated 12/10/24 showed results of acute intra-articular corner fracture at the lateral margin of the left great toe .</p> <p>R1's bruise/injury of unknown origin report showed R1 was unable to state what happened to her left toe due to her poor cognition. The report showed R1's power of attorney elected to not send R1 to the hospital for the injury but to have R1 remain in the facility and follow-up with R1's podiatrist.</p> <p>On 12/18/24 at 1:38 PM, V18 (agency caregiver) stated she was assigned to R1 on 12/8/24 (Sunday), from 8 AM-4PM. V18 stated when she got R1 dressed that morning, she noticed R1's left great toe was bruised and swollen. V18 stated she had received no report of R1 sustaining any falls or injuries prior to her shift. She had also received no reports of bruising or injuries to R1's left foot.</p> <p>On 12/18/24 at 12:32 PM, V17 (agency caregiver) stated she was assigned to R1 on 12/7/24 (Saturday), from 8 AM-4 PM. V17 stated she did not see any injuries to R1's left foot on 12/7/24.</p> <p>The facility's nursing schedule dated Saturday, December 7, 2024, showed the following staff provided cares to R1 on 12/7/24:</p> <p>a) V13 (Registered Nurse/RN) from 7 AM-3PM</p> <p>b) V14 (Nurse) from 11 PM-7 AM</p> <p>c) V12 (Certified Nursing Assistant/CNA) from 3 PM-7 AM</p> <p>On 12/18/24 at 12:55 PM, V13 (RN) stated she did not see any injuries to R1's left foot on 12/7/24. V13 stated R1 did not appear to be in pain on 12/7/24. V13 stated R1 had no falls and/or sustained no injuries on 12/7/24 that she was aware of.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/18/24 at 10:55 AM, V14 (Nurse) stated, (R1) was in bed for my shift but she did not appear to be in pain. I didn't see her feet because they were covered. I received no report of her having any recent falls or injuries .</p> <p>On 12/18/24 at 2:17 PM, V12 (CNA) stated she worked a double on 12/7/24; providing cares to R1 from 3 PM-7 AM. V12 stated she did not see any bruising, swelling or injuries to R1's left foot at any time during her shift. V12 stated, I don't know what happened to her foot. I used the hoyer (mechanical) lift by myself, after dinner, to put her to bed. No one was with me. I know I am not supposed to transfer her using the hoyer by myself but no one was available to help me. She didn't hit her feet at all when I transferred her . V12 stated she also provided incontinence care, twice, to R1 during her shift. V12 stated, I didn't see any injuries to her feet when I changed her either.</p> <p>On 12/18/24 at 11:37 AM, V5 (R1's Physician) stated, (R1) does have history of osteomyelities to her foot which could potentially make it easier to fracture but none the less, her injury was most likely caused by some type of blunt force trauma.</p> <p>On 12/18/24 at 2:00 PM, V2 (Director of Nursing) stated all (resident) mechanical lift transfers are to be completed with two staff members present to ensure a safe resident transfer.</p> <p>The facility's Mechanical Lift Transfers policy dated 8/16/24 showed, There will always be 2 staff present to assist resident. 1 staff will control the lift as the other will guide resident and support back and neck to transfer surface .</p>		