

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER Highlight Healthcare of Morrison		STREET ADDRESS, CITY, STATE, ZIP CODE 500 North Jackson Street Morrison, IL 61270	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40798</p> <p>Based on observation, interview, and record review, the facility failed to assess, care plan and obtain physician orders for 2 of 12 residents (R27 and R22) to self-administer medications in the sample of 12 residents reviewed for medication safety.</p> <p>The findings include:</p> <p>1. On 3/3/25 at 10:22 AM, R27 showed surveyor a box of lidocaine patches (medicated pain patches) in her bedside stand. R27 said she uses them on her right hip for pain. R27 also showed surveyor her inhaler and said the facility gave her both medications to use.</p> <p>R27's Admission Record dated 3/5/25 shows she is a [AGE] year old resident admitted to the facility on [DATE]. R27's Order Summary Report dated 3/3/25 shows an order for Aspercreme Lidocaine External Patch 4% (Lidocaine) apply to lower back topically one time a day for pain, on in AM and off at bedtime. May keep in room and remove per schedule, but it does not show an order for R27 to self-administer any of her medications.</p> <p>On 3/3/25 at 10:19 AM, V2, Director of Nursing (DON), said there are no residents in the facility with orders or an assessment to self-administer their medications. V2 said if a resident wants to self-administer medications, the facility needs to complete an assessment to make sure they can safely perform self-administering of medications, they need an order from the resident's physician, and the care plan needs to reflect the medication self-administration plan.</p> <p>The facility was unable to provide a medication self-administration assessment for R27.</p> <p>35174</p> <p>2. R22's Admission Record showed R22 is a [AGE] year old, cognitively intact resident admitted to the facility on [DATE] with diagnoses which include: chronic obstructive pulmonary disease and congestive heart failure.</p> <p>On 3/3/25 at 10:40 AM, R22 was sitting up in bed with the bedside table across R22 and the bed. R22 had an inhaler sitting on the bedside table. R22 stated she needed the inhaler to take a couple of puffs when she gets short of breath and would not have to wait for the nurse to bring it.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/4/25 at 10:35 AM, V2 Director of Nursing stated there were no residents at the facility who self-administer any medications. A resident needs an assessment and a physician's orders to be able to self-administer medications.</p> <p>R22's Physician Order Sheet printed on 3/3/25 showed R22 having an order for an Albuterol Sulfate inhaler every 6 hours as needed for shortness of breath. This order sheet showed no orders for R22 to be able to self-administer any medications.</p> <p>R22's electronic medical record showed no assessments being completed for R22 to be able to self-administer medications.</p> <p>R22's current Care Plan showed no focus areas pertaining to R22 being able to self-administer medications.</p> <p>The facility's Resident Self-Administration of Medication Policy dated 11/2024 showed a residents interdisciplinary team needs to be assessed, educated, and care planned when a resident is deemed safe to self-administer medications.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>35119</p> <p>Based on observation, interview, and record review the facility failed to ensure the resident shower room was clean, comfortable, and homelike and failed to ensure hot water was available in resident bathrooms. This applies to all 35 residents residing at the facility.</p> <p>The findings include:</p> <p>The facility's Long Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 3/3/25 shows there is a resident census of 35.</p> <p>1. On 3/4/25 at 9:31 AM, in the resident shower room V3 Certified Nursing Assistant pointed out the drain in the floor. The drain was uncovered with a hole exposed (the size of a softball) in the center of the shower room floor, under the shower head. V3 stated this morning I gave a shower and the wheel of the wheelchair got stuck in the drain. Look at this room! The tiles are missing and some tiles tape to hold them up.</p> <p>On 3/4/25 at 1:19 PM, R8 stated I've been here for 9 years and every year I complain about shower room. It was really pretty bad. This is a little better than before. It is still bad though, the walls have holes, tiles are missing, but it is the only place for showers, so I have had to live with it.</p> <p>On 3/5/25 at 9:00 AM, V4 Licensed Practical Nurse said there is only one shower room for all the residents.</p> <p>On 3/5/25 at 9:02 AM, the resident shower room had tiles missing along 3 walls by the floor. One wall on the left side of the room (when standing in the doorway), had exposed wood framing in several areas. One exposed was half covered with a plastic piece of material. Multiple areas on all walls had tiles pushed in. A large area of tiles around the faucet were pushed in and heavily caulked. There were rolled towels on floor to keep water from going out the door and along the left wall. The wall the door was on had tiles held in place with black duct tape.</p> <p>On 3/5/25 at 3:00 PM, V1 Administrator said they are aware of the shower room.</p> <p>The facility's Resident Council Minutes dated 6/18/2024 shows showers need updated.</p> <p>The Facility's Resident Rights for People in Long-Term Care Facilities Policy (from the Illinois Long-Term Care Ombudsman Program shows Your facility must be safe, clean, comfortable and homelike.</p> <p>40798</p> <p>2. On 3/3/25 at 10:08 AM, R29 said there is no hot water in his bathroom. R29 said it freezes in the winter even if they let the water run all night, it never gets warm. After running the hot water continually for two minutes in R29's bathroom sink, the water never got any warmer and still felt cold to the touch.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 3/3/25 at 1:55 PM, R29 and R10's bathroom sink water ran for two minutes. All temperatures taken during this investigation were obtained using a calibrated, digital thermometer. The cold tap water was 65 degrees Fahrenheit (F), and the hot tap water was 55 degrees F.</p> <p>On 3/3/25 at 2:15 PM, V9 said the north wing has issues with the hot water; he does not believe there is a return circuit for the hot water.</p> <p>On 3/4/25 between 9:35 AM to 9:40 AM the hot water temperature in R10 and R29's bathroom sink was 58.9 degrees F. On 3/4/25 between 9:42 AM and 9:46 AM the hot water temperature in R11, R13, and R18's bathroom was 59.2 degrees F. On 3/4/25 between 9:47 AM and 9:52 AM the hot water temperature in R21, R23, and R28's bathroom sink was 60.7 degrees F.</p> <p>The Residents' Rights for People in Long-Term Care Facilities handbook (revised 11/2018) shows, Your facility must be safe, clean, comfortable, and homelike.</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35174</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident was assessed for the use of a restraint which applies to 1 of 1 resident (R20) reviewed for restraints in a sample of 12.</p> <p>The findings include:</p> <p>R20's Admission Record printed on 3/5/25 showed R20 as a [AGE] year old cognitively impaired female resident with diagnoses which includes autistic disorder and Downs syndrome.</p> <p>On 3/3/25 at 8:45 AM, R20 was sitting in a wheelchair with a restraint vest on near the nurse's station. The vest had a strap with a clip on each corner of the vest. One strap went on either side of R20's head and the other 2 straps went under R20's armpits to fasten to the back of the chair.</p> <p>On 3/4/25 at 12:35 PM, R20 was sitting in a recliner in a common area near the nurse's station. R20 started having behaviors, which included pushing over a bedside table, and lashing out towards staff. Staff escorted R20 to her room. At 1:40 PM, V3 Certified Nursing Assistant (CNA) brought R20 out of her room in her wheelchair with the harness in place.</p> <p>R20's physician orders showed no order for a wheelchair harness.</p> <p>R20's medical record showed no restraint assessment completed since admission on 11/5/24.</p> <p>On 3/4/25 at 1:55 PM, V3 stated R20 can move the top 2 straps over their head so the harness is only around her waist. V3 stated they thought R20 was able to unbuckle the clips at her sides. V3 stated when R20 is having behaviors she is an increased fall risk.</p> <p>On 3/5/25 at 10:35 AM, V2 Director of Nursing stated V3 had not had a restraint assessment since her admission.</p> <p>On 3/5/25 at 10:55 AM, V10 CNA stated they had not seen R20 ever undo the harness herself. V10 stated we (care staff) are the ones who undo the harness when R20 needs to get in and out of the chair.</p> <p>The facility did not provide a restraint policy prior to exiting the survey.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>35174</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident's comprehensive careplan included interventions for a chest harness which applies to 1 of 12 residents (R20) reviewed for careplans in a sample of 12.</p> <p>The findings include:</p> <p>During the survey, R20 was observed wearing a restraint harness while in her wheelchair. R20 was utilizing the harness on 3/3/25 at 8:45 AM, 3/4/25 at 1:40 PM and 2:55 PM.</p> <p>R20's Medical record showed no assessment was completed since R20's admission on 11/5/24.</p> <p>On 3/4/25 at 10:35 AM, V2 Director of Nursing stated a restraint should be in a resident's care plan.</p> <p>R20's current care plan showed no focus area or interventions in place for a restraint.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35174</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident's nails were trimmed for a resident with a hand contracture which applies to 1 of 12 residents (R15) reviewed for activities of daily living in a sample of 12.</p> <p>The findings include:</p> <p>R15's Admission Record printed on 3/5/25 showed R15 to be a [AGE] year old male resident, originally admitted to the facility on [DATE] with diagnoses which include a contracture to the left hand and muscle weakness.</p> <p>On 3/3/25 at 10:10 AM, R15 was in his room watching television. R15's nails were noted to be approximately 1/4 inch long. R15 opened his hand with other hand. R15's left palm had indentations from his fingernails pressing into his palm.</p> <p>On 3/4/25 at 9:20 AM, R15 still had long nails with left hand closed.</p> <p>On 3/4/25 at 1:30 PM, V11 Certified Nursing Assistant assisted R15 with opening his hand. R15 had indentation marks from his fingernails in his palm. V11 stated R15's nails were too long (approximately 1/4 inch) and needed to be trimmed. V11 stated when they have taken care of R15 they have not had R15 refuse hygiene assistance.</p> <p>On 3/4/25 at 1:45 PM, V8 Certified Nursing Supervisor stated nails are usually trimmed during a resident's shower. R15's nails were too long.</p> <p>R15's undated (current) Care Plan showed R15 needing activities of daily living (ADL) assistance due to R15 having a stroke which caused R15's left side to be affected.</p> <p>The facility's Activities of Daily Living Policy, dated 5/2024, showed resident care needs will be provided by staff which includes bathing, dressing, grooming and oral care.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>35119</p> <p>Based on observation, interview, and record review the facility failed to ensure elastic bandages (tubi grips) were applied for a resident with a history of lower extremity edema for 1 of 12 residents (R5) reviewed for quality of care in the sample of 12.</p> <p>The findings include:</p> <p>On 3/3/25 at 10:35 AM, R5 was up in her wheelchair propelling herself in the activity room. R5 had socks on to her ankles and her skin was visible above the sock (no elastic wraps were in place).</p> <p>On 3/3/25 at 1:49 PM, R5 was up in her wheelchair in the activity room with no visible elastic wraps on her legs.</p> <p>On 3/4/25 at 1:22 PM, R5 was sitting up in her wheelchair in the activity room with her feet on the floor. V3 Certified Nursing Assistant (CNA) lifted R5's pant leg and R5 only had on socks that came up to her ankles. There were no elastic bandages observed. V3 said she is supposed to have wraps on her legs.</p> <p>On 3/4/25 at 1:24 PM, V4 Licensed Practical Nurse said R5 is supposed to wear elastic bandages during the day for circulation and to prevent edema. V4 said R5 has had the order for some time and R5 doesn't refuse for the staff to put them on. V4 said the elastic bandages are supposed to be on from her toes to her knees.</p> <p>On 3/4/25 at 1:26 PM, V5 CNA said she was assigned R5 today and she didn't put R5's elastic bandages on. V5 said she didn't know R5 was supposed to have them on.</p> <p>On 3/4/25 at 2:01 PM, V2 Director of Nursing (DON) said R5 has had a lot of edema in the past and a history of cellulitis. V2 said R5 sometimes refuses to lay down or elevate her legs in the recliner, she likes to be up and doing things, so the elastic bandages help keep the swelling in her legs down.</p> <p>R5's Physician Orders dated 11/18/24 shows Apply Tubi Grips to BLE [bilateral lower extremities]. Start at toes and go up to knees. Every day and night shift for lower leg swelling on in the AM and off at Bedtime.</p> <p>R5's Care Plan dated 4/9/24 shows, The resident has Congestive Heart Failure:</p> <p>-The resident will be free of peripheral edema through the review date.</p> <p>-Apply Tubi Grips to BLE. Start at toes and go up to knees. Every day and night shift for lower leg swelling ON in the AM and off at Bedtime.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>35119</p> <p>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.</p> <p>The findings include:</p> <p>1. On 3/3/25 at 10:15 AM, R33 was in bed 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.</p> <p>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.</p> <p>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.</p> <p>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 [twice per day] and PRN [as needed] for 30 days.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>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 interventions would contribute to the wound worsening.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>40798</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER Highlight Healthcare of Morrison		STREET ADDRESS, CITY, STATE, ZIP CODE 500 North Jackson Street Morrison, IL 61270	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35174</p> <p>Based on observation, interview, and record review the facility failed ensure water temperatures were monitored and maintained in resident care areas, and failed to ensure a resident's call light was within reach which applies to all 35 residents in the facility.</p> <p>The findings include:</p> <p>1. The CMS-671 document dated 3/3/25 showed the facility census was 35 residents.</p> <p>On 3/3/25 at 1:55 PM, the resident bathroom for rooms [ROOM NUMBERS] (shared bathroom) hot water temperature was 121.5 degrees Fahrenheit (F). An electronic calibrated thermometer was used for this reading.</p> <p>On 3/3/25 at 2:05 PM, the facility's hot water heater thermometer read 125 degrees Fahrenheit. The mixing valve thermometer read 120 degrees Fahrenheit.</p> <p>On 3/3/25 at 2:15 PM, V9 took rooms [ROOM NUMBERS]'s hot water temperature. The reading was 119.4 degrees (F). V9 stated the water temperature is high. V9 stated he was getting higher temperatures than that and turned down the hot water heater to 125 degrees about a week ago. V9 stated he called a local plumber to come out and look at the system. V9 stated they would get back to him after they returned from vacation. V9 stated he did not call any other plumbers after that. V9 stated the temperature for hot water should be around 110 degrees Fahrenheit. V9 Maintenance Director stated he believed the mixing valve was the problem. The mixing valve should be adding cold water to the hot water to bring it down to around 110 degrees to the resident rooms and facility.</p> <p>On 3/4/25 between 9:25 AM and 9:35 AM hot water temperatures were taken of the central hallway resident bathrooms. room [ROOM NUMBER]/103 was 117.9 (F), 102/104 116.7 (F), 105/107 115.4 (F), and 106/108 118.1 (F). The facilities working shower room shower hot water temperature was 115 degrees (F) by the shower head temperature gauge, and 115.8 degrees (F) by laconic handheld thermometer. This shower is the only shower room used by residents in the facility.</p> <p>The facility water temperature logs for January 2025 and February 2025 showed no water temperature over 111 degrees (F).</p> <p>On 3/4/25 at 10:00 AM, V9 stated he did not do other water temperature checks in resident rooms other than on Fridays for regular rounds. V9 stated they did not do any more frequent checks after they had found the temperatures out of normal ranges. V9 stated the temperatures were hotter prior to turning down the hot water heater but did not give a specific temperature.</p> <p>The facility's Safe Water Temperatures Policy dated 12/1/24 (per V1 Administrator) showed the facility should maintain appropriate water temperatures in resident rooms. The water temperature should not exceed 110 degrees Fahrenheit.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Highlight Healthcare of Morrison		STREET ADDRESS, CITY, STATE, ZIP CODE 500 North Jackson Street Morrison, IL 61270	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. R4's Admission Record printed on 3/5/25 showed R4 to be a [AGE] year old female admitted to the facility on [DATE] with diagnoses which include dementia and the need for assistance with personal care.</p> <p>On 3/3/25 at 10:55 AM, R4 was lying in bed with R4's head to the left end of the bed. R4's call light was coiled, out of reach, on the floor under the foot board which was the right end of the bed.</p> <p>R4's Fall assessment dated [DATE] showed R4 to be at high risk for falls.</p> <p>On 3/4/25 at 10:30 AM V2 Director of Nursing stated a residents call light should be placed within reach.</p> <p>On 3/5/25 at 11:00 AM, V10 Certified Nursing Assistant stated a residents call light needs to be within reach and/or secured so they can reach it.</p> <p>The facility's Call Light Policy dated 6/2024 showed staff will ensure call lights will be within reach of resident and secured as needed.</p>		

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NAME OF PROVIDER OR SUPPLIER Highlight Healthcare of Morrison		STREET ADDRESS, CITY, STATE, ZIP CODE 500 North Jackson Street Morrison, IL 61270	
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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>35119</p> <p>Based on observation and interview, the facility failed to post the daily staffing for all 35 residents reviewed for staffing.</p> <p>The findings include:</p> <p>The facility's Long Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 3/3/25 shows there is a resident census of 35.</p> <p>On 3/3/25-3/5/25 upon entering the facility, there were no staffing postings observed near the front door on the entry table or the bulletin boards.</p> <p>On 3/5/25 at 1:25 PM, V8 Certified Nursing (CNA) Supervisor stated staffing is posted in the staffing binder at the nurse's station. V8 said the binder has the monthly and daily schedules for nursing and CNA. V8 said staffing is not posted near the front door for visitors to see. V8 said she was not aware staffing needed to be visibly posted.</p>		

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NAME OF PROVIDER OR SUPPLIER Highlight Healthcare of Morrison		STREET ADDRESS, CITY, STATE, ZIP CODE 500 North Jackson Street Morrison, IL 61270	

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>35119</p> <p>Based on observation, interview, and record review the facility failed to ensure psychotropic medication orders contained a duration for 1 of 6 residents (R33) reviewed for psychotropic medications in the sample of 12.</p> <p>The findings include:</p> <p>On 3/5/25 at 10:30 AM, V1 Administrator said all psychotropic as needed medications need to have a stop date.</p> <p>R33's Physician Orders contained an order dated 1/13/25 for Lorazepam Oral Concentrate 2 MG (milligrams)/ML (milliliter) Give 0.25 ml by mouth every 2 hours as needed for anxiety related to generalized anxiety disorder. The order did not contain a stop date (duration).</p> <p>The facility's Use of Psychotropic Medications Policy dated 3/2025 shows PRN [as needed] orders for psychotropic medication, excluding antipsychotics, shall be limited to no more than 14 days.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40798</p> <p>Based on interview and record review, the facility failed to ensure residents were assessed and offered pneumococcal immunizations upon admission for 2 of 5 residents reviewed for vaccinations in the sample of 12.</p> <p>The findings include:</p> <p>R15's Admission Record dated 3/5/25 shows he was admitted to the facility on [DATE]. R15's Immunizations list provided on 3/5/25 shows no historical or current record of R15 having had or being offered a pneumococcal immunization.</p> <p>R21's Admission Record dated 3/5/25 shows she was admitted to the facility on [DATE]. R21's Immunizations list provided on 3/5/25 shows no historical or current record of R21 having had or being offered a pneumococcal immunization.</p> <p>On 3/5/25 at 10:26 AM, V2, Director of Nursing/Infection Prevention Nurse, said when a resident is admitted , the admitting nurse is supposed to screen the residents for their vaccination status and administer them. V2 said the previous DON, dropped the ball on vaccines.</p> <p>The facility's Pneumococcal Vaccine Policy (reviewed 1/2025) shows, .each resident will be assessed for pneumococcal immunization upon admission . and each resident will be offered a pneumococcal immunization .</p>