STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E124	A. BUILDING _____ B. WING _____	04/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE MANOR	1740 WEST MCCORD CENTRALIA, IL 62801

(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) COMPLETION DATE
F 520	Continued From page 59	F 520		

she was not aware these months had incorrect totals for infections in the building.

A review of the facility's maintenance QI (quality improvement) document for March 2011and April 2011, and it indicated there were no maintenance issues in the building. However, during the survey on 4/6, 4/7, and 4/8/11, several maintenance issues / concerns were identified by the survey team, and on 4/8/11 at 10:30 AM, these were confirmed by E1 and E2 as accurate.

In a telephone interview on 4/14/11 at 2:25 PM, Z2, Medical Director, stated that he did not recall being invited to any recent QA meetings at the facility. Z2 stated that he had been medical director of the facility for several years, and in the past, usually met with the facility department heads quarterly, if not sometimes monthly. Z2 stated that in the past 4 or 5 months the facility had not called to invite him to the QA meetings. Z2 stated he was aware that there was a change in administration at the facility, and a man (E1) was now in charge. Z2 stated he had not heard from E1 either by phone or in writing.

Z2 went on to say that the facility staff usually call him when one of his own residents had a medical need or concern. Z2 indicated as the medical director he had not been asked by the facility to give input on any identified deficiencies, or action plans that might have been developed for resident falls, infection control, or the more recently identified issues with stock medications, and menu concerns. Z2 indicated that in the past months when he was informed of infections in the building, he was usually just given the numbers / totals of how many infections, Upper Respiratory Infections (URI's) and Urinary Tract Infections (UTI's) treated for the month, but had not been asked for input on how to reduce the number or

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BROOKSIDE MANOR	1740 WEST MCCORD CENTRALIA, IL 62801

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F 520	Continued From page 60 prevent specific infections in the building. Z2 indicated he was informed of two residents who had multiple falls in the building, but indicated the facility had not discussed these falls with him as a QA issue.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.690a) 300.690b) 300.690c) 300.1210a) 300.1210b)3)5) 300.3240a) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F9999	Continued From page 61 summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven days a week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. Section 300.3240 Abuse and Neglect	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F9999	Continued From page 62 a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirments are not met as evedenced by: Based on observation, interview, and record review, the facility failed to assess, identify patterns and trends, perform a root cause analysis, and implement effective interventions for falls for three (R1, R9, and R10) of three residents with a history of falls in a total sample of 10. This failure resulted in R10 sustaining multiple head lacerations requiring staples, and a fractured pubic bone. Findings include: 1. R10's physician's order sheet dated 2/11 documented she had a partial diagnoses of Blindness and Status Post Fractures Left Hip in 10/09. R10's Fall Risk Assessment dated 3/19/10 documented she was at high risk for falls. Her care plan originally dated 2/26/09 documented she was legally blind and had the potential for falls related to psychotropic medication use. The care plan documented the following interventions: Aid with transfer as needed; Aid with ADL's (Activities of Daily Living) as needed; Keep environment free of hazards; pushes w/c (wheelchair at times); Encourage res to ask for assistance as needed; May use wheelchair; Encourage to sit/stand slowly; PT/OT (Physical Therapy/Occupational Therapy) to eval (evaluate) as needed; PR 3-5 times per week, exercise to bilater lower extremities x 15 repetitions with 1-2 pound weights, sit stand x 2-3 reps, ambulate as tolerated; Acetaminophen 325	F9999		

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F9999	Continued From page 63	F9999		

milligrams, two tablets every four hours as needed for pain; chair alarm when up in wheelchair." None of these interventions were dated as to when the interventions were implemented.

R10's nurse's note dated 6/10/10 at 12:00 PM documented, "Had 12N (Noon) meal fell in hallway on route to room. Saw getting (up) I (Independently) went to room. C/O (Complained Of) L (Left) rib cage pain B (Bilateral) hip pain full body assess L (Left) FA (Forearm) skin tear where she 'landed. '"

R10's Incident/Accident Report dated 6/10/10 documented the incident which occurred at 12:00 PM. The Report had nothing documented in the section "Additional comments and/or steps taken to prevent recurrence." R10's care plan had no documented revision after this fall.

R10's nurse's note dated 6/15/10 at 7:15 AM documented, "Called to res (resident) room lying on back next to BSC (Bed Side Commode). Alert answering questions approp. (appropriately). Lg (Large) laceration to back of head." R10's nurse's note documented she was sent to the emergency room, and she returned with 5 staples to the back of her head. R10's care plan was updated with the entry " Fell 6/15/10 laceration to head." R10's care plan did not list any new interventions to prevent recurrence of falls.

R10's Incident/Accident Report form dated 6/15/10 documented R10 would be encouraged to ask for assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E124	A. BUILDING _____ B. WING _____	04/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE MANOR	1740 WEST MCCORD CENTRALIA, IL 62801

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F9999	Continued From page 64	F9999		

R10's nurse's note, dated 8/20/10 at 9:15 AM, documented, "CNA (Certified Nurse's Assistant) noted res in doorway got (up) out of w/c et (and) hit R (right) side of head on door frame. The nurse's note documented R10 sustained a 1/2 inch laceration to the right back of head. R10's care plan was not revised after this incident to prevent the recurrence of future injuries. The facility had no Incident/Accident Report regarding this incident.

R10's Minimum Data Set (MDS) dated 9/13/10 documented she was independent with ambulation and transfers, and required no supervision from staff, although she had three previous falls while ambulating independently.

R10's nurse's note dated 10/17/10 at 2:00 AM documented, "This nurse in res's room flushing roommate's G-tube noticed res attempting to get up and put her on her shoes, lost her balance et (and) fell forward this nurse unable to catch res from falling. Bruising noted to L (Left) side of head et (and) eye." There was no documentation in R10's record indicating the facility had reassessed R10 to identify potential causes as to why R10 was falling. R10's care plan was not revised after this incident to prevent her from future falls, or to determine the efficacy of the interventions in place. The facility had no Incident/Accident Report for this incident.

R10's nurse's note dated 11/6/10 documented, "Res was found in D/R @ 0530 laying on R side c/o head hurting pool of moderate amount bright red blood present old wound reopened area cleansed c (with) N.S. (Normal Saline) et steri strips applied c TAO (Triple Antibiotic Ointment)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E124	A. BUILDING _____ B. WING _____	04/15/2011

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F9999	Continued From page 65	F9999		

on wound." There was no revision of R10's care plan to address this fall, or prevent future falls. There was no documentation in R10's record indicating the facility had reassessed R10 to identify potential causes of her falls. The facility had no Incident/Accident Report for this incident.

R10's nurse's note dated 12/21/10 at 10:00 AM documented, "Staff heard noise et (and) to check on (R10) et found her on floor c (with) a small pool of blood starting wheelchair was on IV poll left head close to gerichair wheelchair." This nurse's note documented R10 was sent to the hospital, and received 5 staples to the back of her head. Her nurse's note at 5:00 PM documented, "Found in floor of hallway c (with) moderate amount of blood pooling from L (left) side. Body assessment completed @ this time. Laceration noted 4 cm (centimeters) in size to L side scalp." Again, R10 was sent to the hospital, and received four staples to the left side of her head.

R10's Incident/Accident Report dated 12/21/10 did not address how the facility would prevent R10 from falling. There was no documentation in R10's record indicating the facility had reassessed R10 to identify potential causes as to why R10 continued to fall. R10's care plan was not revised after these incidents.

The nurse's note dated 1/8/11 at 6:00 AM documented "Res found lying on R (Right) side next to w/c (wheelchair) in D/R (Dining Room) floor. No apparent injury." At 11:30 AM the nurse's note documented R10 began to complain of pain in her groin and lower abdomen. The nurse's note documented she was sent to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E124	A. BUILDING _____ B. WING _____	04/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE MANOR	1740 WEST MCCORD CENTRALIA, IL 62801

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F9999	Continued From page 66 hospital at 3:10 pm, and returned with a diagnosis of Fractured Pubic Bone/Pelvis. R10's Incident/Accident Report dated 1/8/11 documented "Res had been up et (and) (down) all noc back et forth from bed to D/R (Dining Room). Fell while pushing w/c (wheelchair) to table tripped states over my feet." The report documented for steps taken to prevent recurrence "C/O (Complained of) severe pain in pubic area et has lg (large) amount of blood in stool. Sent to (hospital at that time." R10's care plan dated 12/9/10 was not revised after this fall to address interventions to prevent future falls, or her fracture pubic bone. The nurse's note dated 1/18/11 at 6:00 PM documented, "Res (Resident) stood up et (and) pulled down pants, tripped over own feet. Small abrasion to L (Left) back side head. Res states 'I thought I was in the bathroom.'" R10's nurse's note documented she was sent to the emergency room, and received 2 staples to the left side of her head. On 4/12/11 at 10:10 AM during an interview with E2, Director of Nurses, DON, she stated R10 was legally blind. She indicated R10 had always walked behind her wheelchair, and would occasionally sit down in the wheelchair and ask for assistance. E2 stated R10 was very difficult, and did what she wanted to. E2 stated R10 fell because she was getting weaker. Although R10's care plan documented she would have a Physical Therapy/Occupational Therapy (PT/OT) evaluation as needed, E2 stated she never was seen by Physical or Occupation Therapy. E2 stated R10 was seen by Restorative Therapy in	F9999		

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	14E124	A. BUILDING _____ B. WING _____	04/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE MANOR	1740 WEST MCCORD CENTRALIA, IL 62801

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F9999	Continued From page 67	F9999		

the facility. E2 stated a chair alarm was applied although she could not recall when. E2 stated she could not recall when the approaches listed on the care plan were implemented, and if they were implemented after the falls occurred. E2 confirmed she could not find any Incident/Accident Reports for 8/20, 10/17 and 11/6/10.

On 4/13/11, E1, Administrator, provided the facility's policy and procedure manual. On the top of each policy there was another facility's name. E1 confirmed this, and stated the facility utilized the policies from one of their "sister facilities" (facilities owned by the same company or managed by the same company). The nursing policies and procedures for "Accident Prevention Program " dated 10/08 documented "FALL/INCIDENT REPORT:

a. Each time a resident falls or is found on the floor, the incident/accident report and fall risk assessment form will be reviewed.

b. After completion of the Incident/Accident Report an entry will be made in the resident ' s nurse ' s notes describing incident/accident.

ACCIDENT PREVENTION PROGRAM:

3. All accidents/incidents will be given to Director of Nursing.

4. Even if no injury, emergency or change in condition is apparent, the resident,s physician will be notified as soon as possible (but not later than 24 hours) if the resident falls or is found on floor.

5. Incident/Accident Reports will be reviewed during the weekly fall meeting. Appropriate interventions and or recommendations will be taken/made as needed.

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	14E124	A. BUILDING _____ B. WING _____	04/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE MANOR	1740 WEST MCCORD CENTRALIA, IL 62801

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F9999	Continued From page 68	F9999		

On 4/14/11 at 2:25 PM during an interview with Z2, R10's physician/Medical Director, he stated he was aware of R10's history of falls, and had sent her to the hospital on numerous occasions. He stated the facility did not ask him for input as the Medical Director as to how to prevent her from future falls.

2. On the initial tour of the facility on 4/6/11, R1 was observed sitting in a wheelchair with a lap restraint. E3, Social Services Director (SSD), identified R1 as having frequent falls with injuries and stated, "He basically is on 1:1 observation due to falls." R1 had a low bed in his room with a mat on the wall.

R1 was admitted to the facility on 8/20/10. On admission R1 was assessed as a high risk for falls due to seizures and a history of falls. R1's Fall Risk dated 2/22/11 scored 14 - High Risk. The facility's Clinical Data Collection Design System Report dated 2/28/11 assessed R1 as totally dependent on one staff for transfers, limited assistance of one person for ambulation, and toilet use. R1's balance is assessed as "Not steady, only able to stabilize with human assistance for seated to standing position, walking, turning around - walking, and moving on/off toilet."

R1's Care Plan dated 12/2/10 identifies a Problem of "Potential for Falls R/T (related to) History of Falls, unsteady gait, seizure disorder." The Care Plan had documentation added, "Fall 8/2, 8/26 (sent of SLU hematoma (epidural), 9/26." There were no further documented falls, or interventions listed after the 9/26/10 date. The interventions in place were not dated. There

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E124	A. BUILDING _____ B. WING _____	04/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETION DATE
F9999	Continued From page 69	F9999		

was no documentation or assessments of the efficacy of the interventions in place at the time of the incidents, or additional implementations added.

On 9/27/10 R1 was admitted to the local hospital due to recurrent falls. The hospital's History and Physical documented (in part) that R1 had a motor vehicle accident in 1971, with traumatic head injuries and seizures. R1 had recurrent falls, history of uncontrolled balance and gait, history of multiple rib fractures due to falls, and history of epidural hematoma with surgery due to falls.

R1's Incident/Accident Reports from December 2010, through March 28, 2011 documented additional falls on 12/17/10, 12/31/10, 1/6/11, 2/24/11, 3/16/11, and 3/28/11.

R1's Incident Report on 12/17/10 at 1:00 PM documented a fall in the Dining Room. R1 removed his lap restraint, and slid to the floor causing a large abrasion 2 cm x 7 cm to his back. There were no new interventions on the Incident Report or his Care Plan.

R1's fall on 12/31/10 at 11:40 PM occurred in his bedroom while in the wheelchair with the lap restraint. The incident report is incomplete, and there is no description of how the incident happened. There was an abrasion to the back (no size documented) listed as the injury. There were no new interventions on the Incident Report or his Care Plan.

R1's fall on 1/6/11 at 10:45 PM documented that R1 took off his personal alarm, came out into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E124	A. BUILDING _____ B. WING _____	04/15/2011

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BROOKSIDE MANOR	1740 WEST MCCORD CENTRALIA, IL 62801

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F9999	Continued From page 70	F9999		

hall and fell. R1 sustained a laceration to the back of his head. R1 was sent to the emergency room for evaluation and treatment of the head injury. There were no new interventions on the Incident Report or the Care Plan.

On 2/24/11 at 1:10 PM R1 fell in his bedroom. He was found sitting on the edge of his bed. He had a scratch and "bump" to his head, a bruised right ear, and a 6 inch abrasion to his lower back. There were no new interventions on the Incident Report or Care Plan.

On 3/2/11, time unknown, R1 walked out of his bedroom, stumbled, slid down the door, and fell on his face. There was no documented injury. There was no new intervention on the Incident Report or Care Plan.

On 4/6/11 at 12:25 PM R1 was in the Dining Room seated in his wheelchair with a lap restraint attached to the wheelchair. R1 repeatedly attempted to stand up in the wheelchair. E5, Certified Nursing Assistant (CNA), placed a gait belt on R1, assisted him to stand, ambulated R1 up the hall into the Television area, and placed him into a large overstuffed chair. R1's gait was very unsteady, and R1's balance was poor. R1 was restless, agitated, and observed attempting to stand up repeatedly. At 1:02 PM E4 ambulated R1 down the hall, and placed him in his low bed. At 1:50 PM R1 was sleeping on his low bed.

On 4/6/11 at 3:30 PM R1 was observed ambulating without assistance in the hallway near his door. There was no audible alarm to alert staff that R1 was transferring, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E124	A. BUILDING _____ B. WING _____	04/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSIDE MANOR	1740 WEST MCCORD CENTRALIA, IL 62801

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F9999	Continued From page 71	F9999		

ambulating independently. This surveyor had to call for staff to assist R1. E2, DON, stated, "Look, he removed his alarm again," as she held up the personal alarm placed in his wheelchair.

During an interview on 4/8/11 at 10:22 AM, E1, Administrator, and E2, DON, acknowledged that R1 continued to fall. Neither E1 nor E2 could determine when new interventions had been initiated, or if new interventions had been attempted after each fall to prevent future falls. E1 and E2 acknowledged that R1 had been placed on 15 minute observation "a long time ago," possibly after his hospitalization in September.

On 4/14/11 at 2:25 PM during a telephone interview with Z2, R1's physician/Medical Director, he stated he was aware R1 had several falls; however, he had not been asked by the facility for any input regarding R1's falls.

3. R9's MDS dated 11-9-10 documented that R9 has moderately impaired cognition, and was totally dependent on two plus persons' physical assistance with mobility and transfer.

R9's Incident/Accident Report dated 12-10-10 documented R9 was sent to a local hospital after "CNA's (Certified Nursing Assistants) were doing bed check et (and) found res (resident) laying next to bed with pool of blood ...her head laying on right side laceration to rt (right) forehead et goose egg to (R) (right) eye et brow area."

R9's Care Plan dated 12-10 to 2-7-11 did not document R9's fall, assessment/monitoring, or interventions to prevent further falls. R9's