STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145911	A. BUILDING ______ B. WING ______	01/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-GIBSON CITY	**620 EAST FIRST STREET GIBSON CITY, IL 60936**

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F 441	Continued From page 40 physician on call was notified and an antibiotic was discontinued. On 1/2/12, R4 was noted to have "fluid filled vesicles across upper abdomen and red streak to side and across back. . . .Res states he has had shingles in the past. {Complains of } itching." Z3 (attending physician) was notified and the Valtrex was started. There is no evidence that any kind of precautions or isolation was initiated. The facility policy regarding Shingles (Herpes Zoster) states that "Until the shingles blisters scab over, the resident is considered contagious and should avoid physical contact with: Anyone who had a weak immune system, pregnant women. . . . Isolate resident while lesions are draining to prevent the spread of infection." On 1/4/12 at 3:00pm, E1 (Administrator) reported that they were moving R4 into a private room with contact precautions in place. According to the MDS of 11/22/11, R4 is usually continent of urine. R4 had a roommate prior to being moved, and used the bathroom on his own that he shared with the roommate and two other residents. 3. On 1/4/12 at 12:00pm E16, CNA(Certified Nurse Aide) provided perineal care for R2 following a bowel incontinence. E16 cleansed stool from R2's rectal/perineal area with gloved hands. Wearing the same contaminated gloves E16 touched R2's linens, clothing, leg, cloth sling for the mechanical lift and the mechanical lift.	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS:	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 41	F9999		

300.610a)
300.1210d)6)
300.3240a)
Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.
Section 300.1210 General Requirements for Nursing and Personal Care
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.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
These regulations were not met as evidenced by:
Based on record review and interview, the facility failed to thoroughly investigate, evaluate root

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145911	A. BUILDING ______ B. WING ______	01/10/2012

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F9999	Continued From page 42 cause, make recommendations, and implement interventions and safety precautions to prevent falls for three of ten residents (R1, R2, R10) sampled for falls, out of a sample of 14. These failures contributed to falls with hip fractures for R1 and R2. Findings include: 1. According to admission records and the current Physician's Order Sheet for 1/2012, R1 has diagnoses including history of Hip Fracture, Dementia, Alzheimer's, Urinary Tract Infection (UTI), Generalized Pain, Insomnia, and Anxiety. The Minimum Data Sets (MDS) of 7/20/11 and 10/20/11 assess R1 with cognitive impairment, requiring supervision only for transfers and ambulation, and history of falls. Fall risk assessments dated 4/28, 7/22 and 10/20/11 all score R1 as a moderate fall risk. The printed careplan dated 8/2/11 states under Safety Notes that R1 fell and fractured her hip at home, and is "forgetful and don't (sic) remember it is not safe to get up and walk in...sock feet." This careplan states that R1 had six falls from admission to 4/20/11, when R1 fractured her left ulna and radius. According to the Occurrence report and corresponding nurses notes, on 4/20/11 at 6:00pm, R1 complained of pain and swelling in the left wrist. R1 reported she had fallen, unwitnessed, but later denied she fell. When reported to Z1 (family member), Z1 stated that she thought she had seen swelling and bruising on 4/17/11, but did not report it. The Physician was not notified until 4/21/11, when R1 had other	F9999		

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F9999	Continued From page 43	F9999		

behavioral symptoms and R1's pain/swelling continued. Upon evaluation, R1 was found to have fractures of the left distal radius and ulna, along with a UTI. The fractures were treated with a sling and antibiotics were given for the urinary tract infection. The incident Follow up Report dated 5/2/11 completed by E2 (Director of Nursing) stated as Root Cause, "Other, unwitnessed. Resident stated that she fell, but 5 minutes later stated that she didn't." Under the section for Recommendations is "None Noted."

Nurses notes state that R1 had increased confusion, agitation and elopement attempts on 5/8/11 and 5/13/11, alleviated by intramuscular (IM) Ativan (anxiolytic). R1 continued to ambulate throughout facility on 5/14/11, and was continuously redirected and reminded to use her walker. On 5/15/11 at 8:00am, R1 ambulated into the dining room, lost balance and fell. The Occurrence Report did not include a follow-up with any root cause, and Recommendations stated "None Noted."

Nurses notes continue that R1 had intermittent episodes of agitation, refusing care, and elopement attempts, including 8/10, 8/12, 9/6, 9/7, and 9/24/11. On 10/21/11, there was a nurses notes and telephone order, "written order to d/c (discontinue) lap buddy" due to R1 being independent with the walker. There were no other notes or assessments addressing any use of a lap buddy.

On 10/24/11 at 5:00pm nurses notes state that R1 was very agitated and was walked outside with staff before being redirected inside. When E6 (nurse) went to give IM Ativan, dark purple

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145911	A. BUILDING ______ B. WING ______	01/10/2012

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F9999	Continued From page 44 bruising was found on R1's left hip and elbow. Notes state, ". . .spoke with 2 CNAs (Certified Nurse Aides). . .pt (patient) is independent of toileting and dressing so staff would not have seen bruise unless pt was getting shower. . . .on Thursday day shift. Pt is confused and she'll fall and get herself up and not report. . . .DON (Director of Nursing) and Admin (Administrator) notified at home. . .Pt up and ambulatory - gait steady. . . very agitated. . ." On 10/25/11 at 12:20am, bruising was also noted on the left outer orbital area. This bruising of unknown origin was not listed on the Occurrence Report log provided by the facility. However, the Occurrence Report states that R1 "fell a few days back". The Follow up Report was not completed, had no Root Cause and no Recommendations. Notes of 10/25 and 10/28/11 state that R1 continued to wander about the facility and attempt to go outside, with IM Ativan given. The Occurrence report dated 10/29/11 at 10:00pm states that R1 was found lying supine on the floor in her room, after previously seeing her in her armchair. R1 stated that she hit her head, she did not bear weight when getting up from the floor, and her wrist was swelling. There were no nurses notes for this 10/29/11 incident, until a late entry after 10/31/11. This late entry stated that R1 was found near the door, and the walker was near the bed. The late entry also said R1 had a "ping pong ball sized bump on the left forehead. . ." R1 was sent to the hospital. The Emergency Report notes R1 as "quite demented." The report states that a CT scan of the head was done and R1 had full range of motion without pain of both hips. R1 returned to the facility at 12:30am on 10/30/11 R1 was sent	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145911	A. BUILDING ______ B. WING ______	01/10/2012

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F9999	Continued From page 45	F9999		

out again on 10/30/11, as x-rays were not done the first time. According to the Preliminary Radiology Report dated 10/30/11, X-rays were noted to be negative for hip fracture, and what was later determined to be an old fracture of the left wrist. However, there is another Radiology Report dated 10/30/11 that noted "most likely impacted, subcapital fracture of the neck of the femur" which has the fax date of 11/2/11. Nurses notes of 11/2/11 state that the x-rays were not new findings. Z3 (Physician) signed this 10/30/11 x-ray report on 11/2/11 and ordered "{treatment and follow-up} by {Z4 (Orthopedist)}." However, the appointment with Z4 was cancelled by the family.

An investigation was conducted for the 10/29/11 fall and Follow up Report completed. The bruise of 10/24/11 was listed as a Recent Occurrence. The Follow up Report listed no Root Cause and no Recommendations. An Ad Hoc meeting list signed by E1 (Administrator), E2 (DON), E3 (MDS/Careplan Coordinator), and E5 (Social Service), states that R1's room was rearranged "to allow more room without obstacles. Fridge was removed and the dresser was taken out. . ." Another timeline list in the investigation stated that "bed alarm applied" on 10/30/11 at 3:00pm. This ad hoc meeting addressed both x-rays for the wrist reviewed per Z4, but did not address hip x-rays.

Nurses notes dated 10/30/11 at 9:00pm state that R1 "stayed in bed since coming back from x-rays. . . Bed alarm placed on bed. Reinforced need to call for help if needing anything. {Left} wrist splint applied. . . taken it off several times and reminded several times of need to keep it on."

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F9999	Continued From page 46 Bruising was again noted on 10/31/11 on the hip and forehead. Nurses notes continue that R1 was ambulatory, occasionally agitated/combative, and attempting to exit on 10/31, 11/2, 11/3, 11/5, 11/7, 11/11 (times three), and 11/18/11 throughout the morning. There was no mention throughout these notes regarding a bed or chair alarm or any other monitoring device. Nurses notes state on 11/18/11 at 1:45pm R1 was "found laying on floor beside bed. Her walker placed outside door. . . laying on L' (left) side. Denies falling. . . does not want to get up. Assisted to bed. Res {ambulates} without difficulty. . . " This incident was not listed on the facility Occurrence Log. The next Nurses Note is 11/19/11 at 9:30pm, stating "heard a yell. . . observe {R1} sitting on floor {with} the appearance of having scooted herself out of room . Stated she had fallen while getting out of bed and had landed on her buttocks. . . no apparent injury. . . bed alarm not sounding. Noted alarm disconnected in a placement and manner consistent with resident's statement of having landed on buttocks from bed; it appears that resident was scooting herself to edge of bed. . . disconnecting alarm in the process. When reconnected, alarm found to be in good working order. . . " The Occurrence Report dated 11/19/11 states under "Preventative measures at time of fall" that the alarm was not sounding, the call light was off, the low bed was in place but no mattress on the floor, and R1 was wearing socks only - not slipper socks. The Follow up Report for the incident was not completed, having "N/A" (not applicable) in all	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145911	A. BUILDING _____ B. WING _____	01/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-GIBSON CITY	**620 EAST FIRST STREET GIBSON CITY, IL 60936**

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F9999	Continued From page 47	F9999		

the blanks. There was no Root Cause and no Recommendations.

Nurses notes of 11/24 and 12/1/11 state that R1 ambulated to the dining room with the walker. On 12/4/11 at 12:30am, notes state that R1 was "{up and down}" most of the night, and "continually requiring reminders to use walker for ambulation. . . complains of hip pain. . . Refused to lie in bed, as she does {not} like the sound of the bed alarm. . . Agitation escalated. . . IM Ativan given. . . .Continues to require 1:1 monitoring. . . ." Nurses notes for 7, 8 and 11:00am on 12/4/11 state R1 was sleepy and did not get up for meals. Notes state that R1 would refuse offers of pain medication.

On 12/5/11 at 7:00am, Nurses Notes state that R1 "lost balance while using walker and fell to floor. . . .it is possible this (hip pain) was a factor in the fall as resident often c/o (complains of) hip pain but declines PRN (as needed) analgesics . . ." At 9:00am, the Physician was notified of the fall, and of "bruise on R' (right) hip that staff states was present prior to fall. . . ." R1 ambulated with the walker the remainder of the day. The Occurrence Report noted that the incident was observed with walker and shoes in place. The Follow up Report was not completed, with no Root Cause and no Recommendations.

Nurses notes on 12/6/11 state that R1 was "up ad lib with walker but needed several reminders to use it even in her room." Also noted on 12/8/11 was R1's dark and foul smelling urine. Staff were unable to obtain a urine specimen as ordered from 12/8 to 12/14/11. There is no evidence that the Physician was notified that they were unable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145911	A. BUILDING ______ B. WING ______	01/10/2012

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 48 to obtain the specimen, or if symptoms of UTI persisted. A late entry note for 12/9/11 written 12/12/11 states that R1's "bed alarm is making her not sleep at night as it sounds when she moves in bed and makes her agitated and upset. . . The night nurse removed her bed alarm and she sleeps much better and she is not upset or agitated." Nurses notes on 12/15/11 at 4:10am state that R1 was "found sitting on floor in room. . . attempted to move left leg pt in severe pain. . . " R1 was sent to the hospital where she was found to have a fractured hip. The Occurrence Report stated that the alarm was not in use at the time of the fall. The Follow up Report was not complete; there was no Root Cause nor Recommendations. Investigation and interviews conducted by E1 noted that R1 was found next to her roommate's bed. Statements by multiple staff members indicate they were unaware if R1 was to have a personal alarm on. Some were aware R1 did have a bed alarm, but thought it had been discontinued. The careplans dated 8/2/11 in the chart and in the CNA book were marked as revised on 10/20 and 10/27/11 respectively. The printed entries under Safety Notes ends with the 4/22/11 fracture of the ulna and radius. The undated goal is that R1 "will demonstrate safe use of my walker." A hand-written entry dated 10/24/11 notes the bruises on L' hip , elbow and orbit, but includes no interventions or further observations. Another hand-written entry states R1 "Fell 10/29/11 fx L' wrist splint to L' arm/wrist she removes 10/30/11	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145911	A. BUILDING ______ B. WING ______	01/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-GIBSON CITY	**620 EAST FIRST STREET GIBSON CITY, IL 60936**

(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 49 applied bed alarm {??} skid material put in chair use of w/c (wheelchair) due to splint L' arm 11/1/11 res removes splint form her L' arm herself." There are no interventions as to monitoring or confirming placement and functioning of bed alarm, nor are there interventions addressing R1 removing splint or alarm. These were all the additional written interventions on the careplan in the CNA book. These entries are written in such a way as to be illegible. Additional hand-written entries in the careplan in the chart include "11/1/11 rearranged room to make more space; 11/18/11 1345 (1:45pm) fell" - crossed out as error; "11/19/ 11 on the floor when she tried to get out of bed; 11/21/11 non skid socks at HS (bedtime); fell 12/5/11 - MD (medical doctor) notified to review for pain control; 12/9/11 removed bed alarm from bed; tabs alarm in bed at noc (night) 12/12/11." Again there is no evidence as to how these interventions were to be implemented and how to ensure that interventions were in place. These entries were also added and written in such a way as to be virtually illegible. Nurses notes dated 12/15/11 by E2 documented a conversation with Z2 (family) regarding the x-ray report of 10/30/11 - "in the course of investigating fall from 12/15/11, an x-ray report was found stating there was a probable fracture of the hip on 10/30/11." Z2 stated at that time that she thought Z4 was "looking at old x-ray" that that the left hip had fused after a fracture in 2010. The next nurses note on 12/16/11 stated that E1 had talked to Z2 to clarify that there was in fact a fracture on the 10/30/11 x-ray, from the fall of 10/29/11, which was "contrary to previous report."	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145911	A. BUILDING ______ B. WING ______	01/10/2012

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 50 The hospital History and Physical of 12/15/11 describe R1 as "very senile. . . .extremely confused/demented. . . yells and screams with palpation of left hip. . .X-ray of left hip and pelvis showed a fragmented intertrochanteric fracture of the left hip." Consultation report by Z4 dated 12/16/11 lists diagnoses of "acute on chronic basicervical/intertrochanteric fracture, left proximal femur," and "profound osteopenia" and UTI. R1 had a left hip replacement on 12/16/11. The Operative Report states, "1. August 8, 2011: Subcapital fracture left proximal femur (Garden III classification). 2. History of falling at her nursing home now with increasing pain to suggest acute-on-chronic fracture/necrosis left proximal femur. . ." Z4's reports on three occasions refers to prior x-ray with fracture on August 8, 2011. Z5 (Z4's office nurse) stated on 1/9/12 at 9:45am that the previous x-rays referred to were indeed from 2010, not 2011 as noted. Z5 also clarified that while Z4 was aware of the wrist x-rays from 10/30/11 and comparing them to previous x-rays, Z4 was never made aware of the 10/30/11 hip x-ray showing fracture. Z5 stated that the consultation which the family cancelled on 11/3/11 was for the wrist and not the hip. Z1 and Z2 (both family) stated on 1/4/11 at 9:30am that the facility did not really do anything about R1's falls "until after about the fourth fall." Family stated that R1 is "feisty" and "has a mind of her own." Family stated that R1 would not be able to use the call light to call for help. Z1 and Z2 stated they were aware of x-rays but thought that the physician may have been looking at old x-rays.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145911	A. BUILDING ______ B. WING ______	01/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 51	F9999		

All of the above information was reviewed with E2 on 1/4/12 at 2:00pm, including the lack of root cause and recommendations. E2 stated that recommendations are placed on the careplan. E2 also confirmed that R1 was to have a personal alarm on at the time of the 12/15/11 fall. E2 stated she thought the references to the 8/8/11 hip fracture was an error in dates by the hospital. E2 was asked but was not able to point out interventions on the careplan to address the falls. E2 was asked again on 1/5/12 at 2:30pm if there was any additional information regarding R1's falls. E2 provided no additional information.

The Ad Hoc investigation by the facility confirmed that staff did not apply the personal alarm as planned. The investigation also states that Z4 "said that there is severe demineralization at the site of injury and that area would continue to fracture due to the condition of the bone." This was confirmed by Z5 on 1/9/12 at 9:45am. E1 also confirmed on 1/9/12 at 10:00am that Z3 was aware of the fracture on the 10/30/11 x-ray, but did not know if Z3 knew that the consult with Z4 had been cancelled by the family. E1 stated that R1 was again ambulating with the walker and Z3 gave no new orders.

2. The Physician Order Sheet dated December 2011 states that R2 has a diagnosis of Dementia and Anxiety. The Minimum Data Set dated 10/10/11 states that R2 has cognitive problems , behaviors and requires extensive assist with transfer, ambulation, dressing, eating, bed mobility and total assist with toileting. The facility fall assessment dated 10/10/11 states that R2 is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145911	A. BUILDING ______ B. WING ______	01/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F9999	Continued From page 52	F9999		

high risk for falls.

The Care Plan dated 10/7/11 states, "I will repeatedly try to get out of my bed or chair without help.....I use a [reclining geriatric chair] to get around....I get anxious and try to get out of my chair at times....I need supervision and reminders to not get up out of my chair by myself. I need you to reposition me when I do this....Sometimes when I get anxious and restless I need to go to the bathroom....Please keep me in a public area and observe me when I am in the chair as much as possible.....Drop the seat to my chair and that will help position me better in the chair....Toilet me on bed checks at night....I take off my clothes at times and also remove my [personal] alarm....Reapply my clothes and alarm........."

The facility Incident/Accident Log documents the following falls for R2: 7/6, 7/16, 8/9, 8/17, 9/17, 10/20, 10/25, 11/5 times 2, 11/6, 11/17, 11/21, 12/5, 12/19 times 2.

The Occurrence Report dated 7/6/11 at 7:55pm states that R2 attempted to self transfer from the wheelchair and fell to the floor with the alarm sounding. The Conclusion documents that R2 is having difficulty with ambulation/transfers and "staff will offer to transfer with assist." The Root Cause states, "Due to resident action or internal risk factors."

The Occurrence Report dated 7/16/11 at 11:00am states that R2 "tripped on her shoe laces...." The Conclusion documents that R2 is having "difficulty with ambulation/transfers" and, medication has been adjusted , a psychiatric evaluation has been requested and a clip on personal alarm will be

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	145911	A. BUILDING ______ B. WING ______	01/10/2012

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F9999	Continued From page 53 used. The Root Cause states, "Due to resident action or internal risk factors." The Occurrence Report dated 8/9/11 at 2:30am states that R2 "was crawling out of bed onto the floor....." The alarm was not sounding. The Conclusion documents that staff will wake and toilet R2 during bedcheck. The Occurrence Report dated 8/17/11 at 7:15pm states that R2 was sitting on the floor in her room by the bathroom. The alarm was not sounding. The report states R2 was last seen at 2:30pm but does not document when R2 was last toileted or repositioned. The Conclusion documents that R2 stated she was trying to go to the bathroom and "does not understand that she should ask for help." Under Conclusion it states the personal alarm was not sounding and the battery was replaced. There are no recommendations documented. The Occurrence Report dated 9/17/11 at 4:30pm states that R2 was walking down the hall, had removed the alarm from the wheelchair, so the alarm was not sounding. The Conclusion documents that staff will wake and toilet R2 during bedcheck. The Conclusion states R2 is not aware of safety issues with ambulation. Staff were instructed to place the "alarm in a position that [R2] could not reach it, and to walk [R2] ...when she appears anxious". The Occurrence Report dated 10/1/11 at 11:15am states that R2 was found "sitting on her bottom on the foot rest of the [geriatric] chair on the floor. Chair was tilted forward." The alarm was not sounding. The Conclusion documents that R2	F9999		

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F9999	Continued From page 54	F9999		

was in the activity room with other residents when she "slid from the seat of her chair onto the footrest." The Conclusion states R2 will be "kept in a public area and observe when she is in the chair." The Root Cause states, "No fault."

The Occurrence Report dated 10/25/11 at 3:15pm states that R2 was sitting in the [geriatric] chair in the common area and "seen sliding herself out of the chair....landed on her buttocks.." The Conclusion documents the "non skid material was in the chair [R2] lifted her buttocks across it..." The Conclusion states, "Maintenance lowered seat in the [geriatric] chair for easier positioning of [R2]." The Root Cause states, "No fault."

E7, Maintenance Director, stated on 1/5/12 at 9:00am that he did not lower the seat of R2's chair. E1, Administrator, stated on 1/5/12 at 10:00am that "the bottom of the [geriatric] chair was not dropped[lowered], the chair would only recline."

The Physician's Progress Note dated 10/25/11 states, ".......[R2] continues to try to get out of chair...."

The Occurrence Report dated 11/5/11 at 4:15am states that R2 was found sitting on the mat on the floor next to the bed. The alarm was not sounding. The Conclusion documents that staff had been toileting R2 on rounds, but were in with other residents when R2 was found. The Conclusion states that R2 removed her gown, with the alarm attached, so it was not sounding. The Conclusion states R2 will be toileted first on rounds.

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F9999	Continued From page 55 The Nurse's Notes dated 11/6/11 at 1:10pm state R2 was sitting on the floor mat next to the bed. The Occurrence Report dated 11/6/11 at 1:10pm states that neither the personal alarm clipped to R2's clothing or the pressure pad alarm was sounding. The Conclusion documents that string for the personal alarm was "too long", so it was shortened and the pressure pad alarm was replaced. The Root Cause states, "Equipment Failure." The Occurrence Report dated 11/17/11 at 1:00am states, "[R2] was sitting in the day room in front of the nurse's station. I heard a noise and looked over to see [R2] tipping her chair over and [R2] landed on the foot rest of her [geriatric] chair.." The alarm was not sounding. The Conclusion states "staff will keep the back of the [geriatric] chair in the lower position to prevent tipping." The Root Cause states, "No fault." The Occurrence Report dated 11/21/11 at 1:30pm states, "[R2] was sitting in the [geriatric] chair in the lobby. [Personal] alarm was clipped to the back of blouse. [R2] was witnessed slipping off right side of foot rest onto the floor...alarm stayed on upper back of ...chair and alarm did not sound....." The Conclusion states "[R2] has been restless in her chair.....Staff will keep [R2] in eyeshot..." The Root Cause states, "Due to resident action or internal risk factors." The Physician's Progress Note dated 11/22/11 states, "...[R2] continuously tries to wriggle out of chair..." The Occurrence Report dated 12/5/11 at 11:45pm	F9999		

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F9999	Continued From page 56 states R2 was sitting on the floor in her room with the alarm sounding. The report states that R2 was toileted at 9:30pm and last seen at 11:00pm. The Conclusion states R2 had been in bed sleeping on staff rounds........a body pillow will be placed in front of [R2] when she is in bed....." The Root Cause states, "Due to resident action or internal risk factors." The Occurrence Report dated 12/19/11 at 5:00am states R2 was on the floor in the hall outside of the dayroom, "crawling on hands and knees......CNA[Certified Nurse Aide] stated that prior to (apparent) fall, she had been bringing [R2] with her as she performed tasks...CNA took [R2] to dayroom with another resident and television in an attempt to offer ....alternative stimuli....." The report documents R2 was last seen at 4:45am, but does not document when R2 was toileted last. The Conclusion states, ".... [R2's] personal alarm was in the unit, but was not clipped to her clothing....Female peer in room stated that [R2] unclipped it herself. Staff will clip lower so that [R2] cannot reach it..." The Root Cause states, "Due to resident action or internal risk factors." The Occurrence Report dated 12/19/11 at 6:45pm states, "[R2] napping in [geriatric] chair after supper in west day room. [R2] ...sleeping at [6:30pm]. At [6:45pm].....[R2] lying on the floor." The report states the personal alarm was on but not sounding. The report states R2 was last observed at 6:30pm but does not document when R2 was last toileted. The Root Cause states, "Due to resident action or internal risk factors." The Nurse's Notes dated 12/19/11 at 6:50pm	F9999		

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F9999	Continued From page 57 state R2 was sent to the hospital following the fall. The Radiology Report dated 12/19/11 states R2 has an "Acute right hip fracture, probably basicervical location with varus deformity and Osteoporosis." The statement dated 12/19/11 written by E12, CNA, states R2 was taken to the west day room from the dining room at 5:45pm. R2 was left sleeping in the day room in the geriatric chair with the personal alarm in place. E12 then left to provide care to other residents. At 6:45pm while walking down the hall, E12 saw R2 lying on the floor. The statement dated 12/19/11 written by E13, CNA states at 6:30pm she observed R2 sleeping in the chair in the west day room with the alarm in place. E2, Director of Nursing, stated on 1/5/12 at 9:30am stated that R2 would remove her clothing and the alarm which was clipped to her clothing. E2 stated R2's family brought clothing which was harder for R2 to remove and then R2 would unclip the alarm and remove it. E2 stated they then tried clipping the alarm where R2 could not reach it. When asked about R2's falls on 12/19/11(5:00am and 6:45pm) while in the dayroom unsupervised, E2 stated, "I agree. Can't put [R2] in the day room and I've told staff that." E2 was asked about the root cause analysis of R2's falls, as to why R2 was getting up continuously and stated staff will walk R2 when she gets anxious. E2 was asked for any further documentation detailing the root cause analysis of R2's falls. As of 1/9/12 at 11:40am E2 had not	F9999		

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F9999	Continued From page 58 provided any further information. 3. The January 2012 Physician Order Sheet states R10 has a diagnoses of Dementia and a Fall with Ankle Fracture at home prior to admission on 4/25/11. The Nurse's Notes dated 12/14/11 at 9:15pm state R10 was found on the floor in the bathroom and has a 4 cm (centimeter) bump on the back of the head. The Occurrence Report dated 12/16/11 at 8:30am states that R11 is complaining of pain to his right buttocks and has a bruise on the right buttock measuring 5cm by 5cm from a fall on 12/14/11. E2, Director of Nursing, stated on 1/5/12 at 2:30pm that she could not find an Occurrence Report or Investigation for R10's fall on 12/14/11. B	F9999		