STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E593	A. BUILDING ______ B. WING ______	01/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN MANOR	120 WEST MAIN ALBION, IL 62806

(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 465	Continued From page 40 4. The stove hood was in need of cleaning. 5. A wall between the kitchen and the storage room had loose plaster and paint crumbing from it, which accumulated on the floor on the kitchen side and on the storage room side. 6. The plastic tops of several dry food bins in the storage room were overed with a dark, dusty substance. According to the Resident Census and Conditions of Residents report dated 1/8/13, the facility has 29 residents.	F 465		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.1210a) 300.1210b) 300.1210d)6) 300.1220b)2)3) 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	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E593	A. BUILDING ______ B. WING ______	01/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN MANOR	120 WEST MAIN ALBION, IL 62806

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F9999		F9999		

Continued From page 41

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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E593	A. BUILDING ______ B. WING ______	01/11/2013

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REST HAVEN MANOR	**120 WEST MAIN ALBION, IL 62806**

(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 42	F9999		

each resident's comprehensive resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures:

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 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E593	A. BUILDING ______ B. WING ______	01/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN MANOR	120 WEST MAIN ALBION, IL 62806

(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 43	F9999		

condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
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 Regulations were not met as evidenced by:

Based on record review and interview, the facility failed to thoroughly investigate and develop effective interventions to prevent the reoccurence of falls and/or failed to provide required assistance with transfers for 4 residents (R1, R3,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E593	A. BUILDING ______ B. WING ______	**01/11/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN MANOR	**120 WEST MAIN** **ALBION, IL 62806**

(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 44	F9999		

R5 and R10) reviewed for falls. These failures resulted in a two day hospitalizastion for R10. R10 sustained a Concussion, Laceration to the head which required 13 stitches and Lacerations to both arms which required repair with thin adhesive strips.

Findings include::

1. R10 was admitted to this facility on 1/18/12 as noted on the "Fall Risk Assessment" form .This form indicates a score of 10 and above as high risk for falls'. On the day of admission the assessment indicated a score of 10 for R10 and that R10 had no falls in the past three months and was independent with ambulation.. The 1st quarter assessment dated 4/19/2012 indicated a score of 15 and noted 2 falls occurring in the past three months. A 3rd quarter assessment dated 7/6/12 also showed the fall risk score at 15, with 2 more falls having occurred in the past three months.All three of these assessment dates indicates that R10 required use of an assistive device, and had balance problems while standing and walking.

The 1st thru 3rd quarter assessments as well as the admission assessment for falls indicated that R10 was receiving 4 medications that could contribute to falls. These assessments also indicated that R10 had 2 predisposing diseases which could contribute to a higher fall risk. these were noted as Arthritis and Osteoporosis. Other diagnoses found on the Physician Order Sheet for November 2012 included Dementia.

R10 had 7 documented falls during the timeframe of February to December 2012, that were found

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E593	A. BUILDING ______ B. WING ______	01/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN MANOR	**120 WEST MAIN** **ALBION, IL 62806**

(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 45	F9999		

by review of the nurses notes and the facility incident reports.

A 2/18/2012 Incident Report of a fall occurring at 7:15 pm indicated there was no injury. R10 stated that she had taken her hand off her walker to throw a cup in the trash, lost balance and fell. The undated Post Incident Assessment indicated a potential intervention to be "Will monitor for pattern of falls".

The next fall that was noted occurred on 8/22/12 at 4:05 am when R10 took self to the bathroom and fell as she was trying to close the bathroom door. R10 sustained skin tears to both lower legs, right elbow and bruising to both upper arms that were treated at the facility.
The undated Post Incident Assessment indicated that R10 was advised to allow use of a body alarm but declined to allow and declined to use a call light.

A 9/22/12 Incident Report of a fall at 2:15 pm indicated that R10 was found on the floor of her room on her right side with her walker toppled over on its back. R10 sustained lacerations on her left arm, right knee and face and was sent to the emergency room for evaluation. R10 returned the same day .The Post Incident Assessment indicated that R10 refuses to use call light, recommends R10 use call light and indicates that the facility will re-evaluate use of body alarm.

R10 had a fall on 10/15/2012 at 6:15 pm as noted on the Incident Report. The report indicated that R10 did not lock the wheels of her wheelchair to transfer and the chair rolled away as resident stood, causing resident to fall onto her buttocks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E593	A. BUILDING ______ B. WING ______	01/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN MANOR	**120 WEST MAIN** **ALBION, IL 62806**

(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 46	F9999		

.There was no injury. There was nothing on the undated Post Incident Assessment to indicate that the facility considered any possible additional interventions. It did note that the wheel chair wheels were not locked.

Further review of Incident Reports dated 11/18/12 and 11/19/12 found the following:
11/18/12- R10 attempting to get to the bathroom using her wheeled walker which rolled out in front of her causing her to fall on her bottom. R10 reported no injuries and none were noted by staff. There were no potential interventions indicated on the undated Post Incident Assessment. It again indicated that resident is instructed to use alarm or call light but refuses.
11-19-12 ar 11:05 am R10 was attempting to get to her wheel chair using her walker and it rolled away when she reached out for it, causing her to fall. There was no injury reported or found by staff. The undated Post Incident Assessment indicates R10 has intermittent disorientation and does not use the wheeled walker appropriately, refuses motion sensor use and staff assist. No new interventions were documented as having been considered.

The last fall that R10 had was on 12/17/12 at 2:15 am as noted on the Incident Report of same date. R10 was heard yelling and found on her bathroom floor bleeding from her head and multiple skin tears. R10 stated that she had just stood up and fell. Her walker was noted to be turned over in front of her with a large pool of blood under the walker .The physician was contacted and R10 was sent to the emergency room for evaluation and admitted.
The 12/17/12 History and Physical from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E593	A. BUILDING ______ B. WING ______	01/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN MANOR	**120 WEST MAIN** **ALBION, IL 62806**

(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 47 hospital indicated that R10 had a laceration to her head and on arms with "raccoon eyes-bilaterally and a large hematoma of the face and cheeks". Stitching was required to the forehead laceration and steri strips were applied to the lacerations on the arms. R10 returned to the facility on 12/19/2012 with a diagnoses of a Concussion and Lacerations. The care plan in use had a review date of 10/10/12. Interventions for 'risk for falls' included keeping call light within reach at all times, keeping wheeled walker within reach, keeping bed in lowest position, applying non skid socks to feet and taking to bathroom frequently. After the 10/11/12 fall- an intervention of side rails up, body alarm attached as needed and will allow- may get out of bed around side rail or remove body alarm-monitor closely was added to care plan. On 11/15/12 care plan was updated with "family aware of risk and residents right to be independent." On 11/27/2012 a note on care plan indicates that "resident is very resistant to redirection and reminders to use walker, call light and staff assist. Family do not wish for interventions R10 does not accept." There is no indication that the facility completed a comprehensive assessment of these repeated falls to assess such issues as medications, possible use of a different type walker or other assistive device, possible room change so that R10 would be closer to nurses station for easier monitoring. there was no indication that staff had attempted to try restorative exercises for strengthening and transfer training. E1, Administrator, stated on 1/10/13 at 4:00 pm that R10 and her family wanted R10 to be allowed	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E593	A. BUILDING ______ B. WING ______	01/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN MANOR	120 WEST MAIN ALBION, IL 62806

(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	F9999		

as much independence as R10 wished and knew that falls were possible.

2. According to a facility Incident Report, R3 was found on the floor in her bedroom on 6/18/12 at 9:50 a.m., after becoming sick. The report indicates that there was evidence of blood on the floor, and that R3 sustained an abrasion to the right side of her head and swelling to her shoulder.Under the category titled :Potential Interventions (What Can Be Done to Prevent Further Incidents) a line was drawn through choices and "NA" was written (not applicable).

According to a facility Incident Report, R3 was found on the floor in her bedroom on 07/1/12 at 1:00 a.m. The report indicates that R3 was wearing "slick socks" and was "reminded to wear non-skid socks", and that the bed was set at a lower level.

According to a facility Incident Report, R3 was found on the floor in her bedroom on 8/18/12 at 2:40 (a.m. or p.m. not specified) and sustained a large hematoma to the left upper arm. Under the category titled :Potential Interventions (What Can Be Done to Prevent Further Incidents) staff wrote "encourage to ask for assistance."

According to a facility Incident Report, R3 was found on the floor in her bedroom on 8/18/12 at 12:40 (a.m. or p.m. not specified). Under the category titled :Potential Interventions (What Can Be Done to Prevent Further Incidents) staff entered, "non-skid slipper socks."

According to a facility Incident Report, R3 was

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E593	A. BUILDING ______ B. WING ______	01/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN MANOR	**120 WEST MAIN ALBION, IL 62806**

(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	F9999		

found on the floor in her bedroom on 9/17/12 at 12:15 a.m. According to the report, R3 stated, "I hit my head hard," and complained of a headache. Under the category "Environmental Hazards" the report notes "soft fuzzy socks - Staff instructed to ensure non-skid at H. S. (bed time)."

According to a facility Incident Report, R3 fell on the floor in her bedroom on 9/25/12 at 9:20 a.m. The report states that R3's incontinent brief was "very soiled and wet." The Post Incident Assessment, including Potential Interventions (What Can Be Done to Prevent Further Incidents) was left blank.

According to a facility Incident Report, R3 fell on the floor in her bedroom on 10/5/12 at 5:45 p.m., and sustained a scratch to her left arm. Under the category of "Environmental Hazards" the report notes "has FWW (walker) available - did not remember to use." Under the category titled :Potential Interventions (What Can Be Done to Prevent Further Incidents) "staff assist" is checked.

According to a facility Incident Report, R3 fell in the hallway near the nurse's station on 11/30/12 at 9:30 (a.m. or p.m. not specified), sustaining bruises and abrasions to the left elbow and left forehead. Potential Interventions (What Can Be Done to Prevent Further Incidents) was left blank.

According to a Nurse's Note dated 10/9/12 at 4:45 p.m., "Staff reported to nurse res (resident) R (right) eye appears slightly swollen et bruised; reported that during transfer of room mate to wheel chair prior to lunch et (and) this res was sitting in her recliner next to res room mate wc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E593	A. BUILDING ______ B. WING ______	01/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN MANOR	**120 WEST MAIN** **ALBION, IL 62806**

(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	F9999		

(wheelchair)." The corresponding Bruises, Marks, or Skin Tears dated 10/9/12 states that while staff were transferring R3's roommate with a mechanical lift, a bed pad shifted and hit R3 in the eye. The report indicates that in order to prevent a recurrence, staff will close the privacy curtain in the future.

On 1/11/13 at 1:30 p.m., E1, Administrator, stated that R3 was actually accidentally hit in the eye by a wheelchair pad in the the incident.

3. An Incident and Accident report dated 02/21/12 notes R-1 fell while attempting to get newspaper from behind chair at 9:00 PM. The intervention noted was for R-1 to ask for assistance. An Incident and Accident report dated 05/22/12 at 10:45 PM notes R-1 fell while going to the bathroom and sustained a fractured hip. The Nurse's Progress Notes prior to the May 2012 incident indicates that R1 was able to ambulate independently safely. The only intervention noted again, was for R-1 to ask for assistance. The past two Minimum Data Sets dated 06/02/12 and 11/28/12 note R-1 has moderate cognitive impairment and requires two staff to assist him with transfers. An Incident and Accident report dated 08/10/12 notes R-1 was being assisted during a transfer by one person and R-1 had to be lowered to the floor, no interventions were implemented after this incident.

4. According to the Nurse's Progress Notes, R5 has had 7 falls since 09-23-12 with no serious injuries.According to the notes these falls were described as the following. On 09-23-12, R5 fell out of a chair. On 09-30-12, R5 fell in the bathroom.On 10-14-12, R5 fell backwards.On

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E593	A. BUILDING ______ B. WING ______	01/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN MANOR	**120 WEST MAIN** **ALBION, IL 62806**

(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 51 11-03-12, R5 found sitting in the floor. On 11-14-12, found again on the floor.On 11-16-12, R5 was found on the floor again. On 12-23-12, R5 was again found on the floor but this time in the dining room. R5's facility Incident Report Forms for these falls were reviewed. These Incident Report Forms include a post incident assessment section that addresses potential interventions. The interventions section is blank or includes interventions that are not specific or appropriate for this confused resident. According to R5's Minimum Data Set dated 11-21-12, R5 has long and short term memory problems. (B)	F9999		