STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145452	A. BUILDING _____ B. WING _____	C 03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-DWIGHT	**300 EAST MAZON AVENUE DWIGHT, IL 60420**

(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 000	INITIAL COMMENTS Facility Reported Investigation to Incident of 2/17/2021/IL131631	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to implement wheel chair safety interventions for one resident (R1) of three residents reviewed for accidents in the sample of three. This failure resulted in R1 being improperly transferred and R1's leg becoming entrapped under the wheelchair resulting in a fracture at the distal metaphysis of the right femur. Findings include: The facility's Adverse Event Policy, dated 11/2017, documents an adverse event is an untoward undesirable, and usually unanticipated event that causes death or serious injury, or the risk thereof, which includes near misses. On 3/10/21 at 8:45am, R1 was in a reclining chair with her legs elevated, crying. R1 stated that she cannot talk until the pain medications take effect. R1 had immobilize brace in place on her right knee/leg.	F 689	F689 Free of Accident Hazards/Supervison/Devices 1. Corrective Action Taken for Resident Affected by Deficient Practice A. Care plan was reviewed and updated. 2. Identification of Other Residents having Potential to be affected by the same deficient practice. All residents that do not self propel w/c have the potential for being affected by the deficient practice. 3. Measures Taken to Ensure That Deficient Practice Does not Reoccur A. Foot Pedal assessments will be completed at admission and updated as needed. B. Restorative nurse will do random audits for compliance.	4/1/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/01/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145452	A. BUILDING _____ B. WING _____	C 03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-DWIGHT	**300 EAST MAZON AVENUE DWIGHT, IL 60420**

(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 689	Continued From page 1 R1's Incident Report, dated 2/17/21, documents that R1 was being pushed to the bathroom and her foot dropped and R1 stated "I heard something crack". R1's right knee x-ray, dated 2/17/21 documents an acute comminuted fracture at the distal metaphysis of the right femur. On 3/10/21 at 10:45am, V4, Unit Assistant, stated that she was pushing R1 back to her room, when R1 dropped her right foot and it went under the wheel chair. V4 stated that R1 said "I heard something crack." V4 verified that R1 did not have her foot pedals on her wheel chair. On 3/10/21 at 11:00am, V5, Licensed Practical Nurse, stated that V4, Unit Assistant, was pushing R1 back to her room, and heard a scream. V5 stated that R1 dropped her right foot, it went under the wheel chair. V5 stated that R1 did not have the foot pedals on the wheel chair. V5 stated that when R1 is being transported in the facility, her foot pedals should have been on. On 3/11/21 at 9:00am, V3, Restorative/Registered Nurse, stated that R1 should have had the foot pedals on her wheel chair when being transported by staff.	F 689	C. In-service staff on need for w/c pedals for residents who do not self-propel. 4. Quality Assurance A. The QA Committee will monitor for compliance reviewing random audits at the next QA meetings. Completion Date: March 29, 2021	