STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145979	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON COMMUNITY HSP ANNEX	430 EAST 19TH 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
F 000	INITIAL COMMENTS	F 000		
F 226	Annual Licensure and Certification Survey 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to have an abuse prevention policy which was reflective of the regulatory requirement, that the Administrator be notified of all allegations of abuse, neglect, mistreatment and misappropriation of property. The policy does not address injuries of unknown origin and catastrophic reaction as they relate to abuse. This has the potential to affect all 13 residents residing in Medicare/Medicaid certified beds. Findings include: The facility's Abuse and Neglect Prevention policy dated 3/20/12 states: "Suspected abuse or neglect will be immediately reported to the Administrator or Director of Nursing." The policy is void of criteria for identifying injuries of unknown origin requiring investigation related to abuse. The policy does not include a definition of catastrophic reaction and appropriate staff interventions. On April 10, 2012 at 3:45 pm, E1, Administrator stated she was the Abuse Prohibition	F 226		4/20/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 226	Continued From page 1 Coordinator. E1 confirmed that the current abuse prevention policy, as written, directs staff to report all allegations to the Director of Nursing or the Administrator. E1 stated there was no inclusion in the current policy of any criteria addressing injuries of unknown origin or catastrophic reaction. The Resident Census and Conditions Of Residents form dated 4/9/12 indicates there are a total of 13 residents residing in the Medicare/Medicaid certified beds.	F 226		