STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E327	A. BUILDING _____ B. WING _____	C 11/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINCKNEYVILLE HEALTH CARE CTR	708 VIRGINIA COURT PINCKNEYVILLE, IL 62274

(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 225 SS=D	Complaint Investigation #1354839 / IL66754 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working	F 225		

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 225	Continued From page 1 days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to thoroughly investigate a fracture of unknown origin for 1 of 3 residents (R21) reviewed for abuse allegations in the sample of 8. Findings include: The November, 2013 Physician's Orders state R21 has a diagnosis of Osteoporosis with a history of a Cerebrovascular Accident with left hemiparesis. The 10/31/13 "Investigation of Skin Tear Bruises and Abrasions" report states a bruise of unknown origin was found on R21's left deltoid at 1500 during a shower. The "Conclusion of Investigation" dated 11/05/13 states on 11/01/13, R21 began to complain of pain and an x-ray was ordered and a fracture was noted. E2 (Director of Nurses) stated during interview on 11/20/13 at 11:30AM, that she interviewed every Certified Nurse Aide (CNA) that worked on 10/31/13 and 11/01/13 and there was no indication of abuse. The October, 2013 "Behavioral Tracking Sheet states R21 has a behavior of being combative during care. The log states on 10/30/13 that R21 had 3 episodes of being combative during care on the 2PM - 10PM shift with an "O" in the "outcome" column indicating the behavior was "unimproved". Review of the "Monthly Staff Schedule" for	F 225		

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F 225	Continued From page 2 October, 2013 documents E46 (CNA) and E47 (CNA) worked 10/30/13 on the 2PM - 10PM shift. Review of the "Witness Statement Form" documents E46 and E47 were not interviewed regarding the details of the behaviors that occurred on 10-30-13 in relation to the development of the bruise/fracture of unknown origin.	F 225		
F 226 SS=D	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 record review and interview the facility failed to provide evidence that the facility's Abuse Prevention Program Facility Procedures regarding a thorough investigation for a fracture of unknown origin was followed for 1 of 3 residents (R21) reviewed for potential abuse in the sample of 8. Finding include: The November, 2013 Physician's Orders state R21 has a diagnosis of Osteoporosis with a history of a Cerebrovascular Accident with left hemiparesis. The 10/31/13 "Investigation of Skin Tear Bruises and Abrasions" report states a bruise of unknown origin was found on R21's left deltoid at 1500 during a shower. The "Conclusion	F 226		

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F 226	Continued From page 3 of Investigation" dated 11/05/13 states on 11/01/13 R21 began to complain of pain and an x-ray was ordered and a fracture was noted. E2 (Director of Nurses) during interview stated on 11/20/13 at 11:30AM, that she interviewed every Certified Nurse Aide (CNA) that worked on 10/31/13 and 11/01/13 and there was no indication of abuse. The October, 2013 "Behavioral Tracking Sheet states R21 has a behavior of being combative during care. The log states on 10/30/13 that R21 had 3 episodes of being combative during care on the 2PM - 10PM shift with an "O" in the "outcome" column indicating the behavior was "unimproved". Review of the "Monthly Staff Schedule" for October, 2013 documents E46 (CNA) and E47 (CNA) worked 10/30/13 on the 2PM - 10PM shift. Review of the "Witness Statement Form" documents E46 and E47 were not interviewed regarding the details of the behaviors that occurred on 10-30-13 in relation to the development of the bruise/fracture of unknown origin. The facility's undated "Abuse Prevention Program Facility Procedures" states: "VI Internal Investigation of Abuse, Neglect or Misappropriation Allegations and Response 3. For any other incident or pattern involving "reasonable cause to suspect abuse, neglect or misappropriation" (210 ILCS 30/4), the administrator will appoint a person to gather further facts prior to making a determination to conduct an abuse investigation." E52 (Executive Director of Southern Illinois Management System) stated on 11/25/13 at 10:00AM he thought the staff working 10/30/13	F 226		

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F 226	Continued From page 4 were interviewed regarding R21's fracture.	F 226		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A. Based on observation, record review and interview the facility failed to maintain the residents environment free of thermal hazards. This has the potential to affect all of the 33 residents living in the facility. The findings include: The Facility Data Sheet prepared by E1 (Administrator) on 11/20/13 documented that the facility census was 33 residents. 1. During a tour of the facility on 11/20/13 a space heater was noted in use in the therapy office at 10:30am. When tested at 10:40 am with a thermal testing strip the surface temperature reading exceeded 180 degrees Fahrenheit. At 11:00am interview with R22 (Restorative Certified Nurse Aide) indicated that she uses the heater due to the cold temperatures in the office and that she brings residents in to complete	F 323		

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F 323	Continued From page 5 some physical therapy. R22 further stated that she unplugged the space heater before the residents entered the room. 2. At 1:45pm, the C-hall shower room was observed to have a small heater enclosed in the wall between the toilet and shower areas. Interview with E16 (Certified Nurse Aide, CNA) who was in the shower room at the time of the observation found the unit is automatic and turns on and off by itself. When asked about adjusting the temperature, E16 indicated that the control knob was kept with the nurse in the medication cart. When tested at 2:10pm with a thermal testing strip the surface temperature reading exceeded 180 degrees Fahrenheit. On 11/15/13 at 10:50am E4 (Certified Nurse Aide-CNA) stated that any of the 33 residents who reside in the facility could be toileted or bathed in the C-hall shower room. E4 indicated that it is the largest and most commonly used shower room. 3. Interview with E1 (Administrator) on 11/20/13 at 3:20pm found that space heaters are used in the facility in several offices due to the lack of working heat in those rooms. E1 stated the heat is not functioning in her office, the care plan office and the physical therapy office. 4. When the thermal hazards were brought to the attention of E1 and E53 (RN, Southern Illinois Management System) on 11/20/13 at 3:20pm, the units were removed from the facility and repairs to the heating system were initiated. B. Based on observation and record review the	F 323		

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F 323	Continued From page 6 facility failed to ensure working and activated alarms were in place for 1 of 5 residents (R1) reviewed for Personal Safety Alarms (PSA) in the sample of 8. The findings include: A review of R1's medical record and admission documentation found R1 was admitted to the facility on 11/17/12 with diagnoses including: Dementia, Cerebral Vascular Accident and Cardio Vascular Disease. R1's care plan, last up-dated 10/14/13, states as a problem " Requires a bed/chair alarm related to lack of safety awareness. Has history of falls with attempted independent transfers and ambulation..."and "will be free from injury related to falls as a goal." The approach on this care plan in relation to this safety awareness problem indicates that a chair alarm is to be used at all times while in chair, wheelchair. R1 was observed in his room at 9:15am on 11/21/13, in a wheelchair with a pad alarm in the chair. E22 (Restorative CNA) stood R1 at that time and the alarm failed to sound. E22 stated that the alarm had been working yesterday when R1 attempted to stand alone. E22 felt that the battery must have been dead at the time of the observation and made arrangements to have the battery changed. R1 was observed in his room at 10:00am on 11/21/13, in a wheelchair with a pad alarm in the chair. E16 (CNA) looked at the chair alarm in R1's chair and stated that the alarm control box should have a flashing light. E16 picked up the alarm and indicated the alarm was in the "off"	F 323		

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F 323	Continued From page 7 position.	F 323		