STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145447	A. BUILDING ____ B. WING ____	C 08/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE MANOR-ELGIN	**355 RAYMOND STREET** **ELGIN, IL 60120**

(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 Complaint Investigation 0973516 / IL43068 No extended survey was conducted.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS 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	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 survey and certification agency) within 5 working 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 facility, staff, and resident interview, the facility failed to complete a thorough accident investigation of R1's fall to include witness information. Examples include: Interview with R 10 on 8/19/09 revealed that he witnessed the accident on 8/6/09. R10 stated that "R1 was standing on the bed, messing around with the window shade, trying to pull it down. The blind fell from the window. R1 picked up the blind and was trying to put it back in place and fell backward landing on the floor." R 10 stated R1 complained of his head hurting, and there was some bleeding. R10 stated he called for nurse (E8) who came right away. R10 stated R1 was taken to the hospital. R10 stated he was never asked by anyone what happened to R1. R10 showed the surveyor his closet and showed the window shade that fell from the window. The window shade was approx. four feet wide. Interview with E8 on 8/19/09 at 2: p.m: E8 stated that R10 told her that R1 was kneeling on the bed and fell backward.	F 225		

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F 225	Continued From page 2 R10 was again asked at 2:15 p.m. about the fall and again stated and demonstrated how R1 was standing in the bed and fell backward and not kneeling. E1 (administrator) and E2 (director of nurses) was told about the inconsistency in what was witnessed by R10 and no staff interviewing him. E2 said she thought R10 told her he was kneeling. There was no interviews or statements included in the accident report completed by the facility obtained from R10 on what happened on 8/6/09 .	F 225		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279		

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F 279	Continued From page 3 by: Based on record review and facility, staff, and resident interview, the facility: 1. Failed to develop a individualized care plan for R1, identified as being at risk for falls. 2. Failed to complete a through accident investigation of R1's fall. 3. Failed to follow the care plan for the treatment of R10's urinary retention. 4. Failed to revise and develop a plan for the monitoring of R10's bladder function after the indwelling catheter was discontinued. Examples include: R1 was admitted to the facility on 7/19/09. During R 1's admission process to the facility on 7/19/09, Z4 (family member) told the facility staff E9 (nurse) that R1 had 52 falls at home before admission. The care plan developed for falls documented the facility assessed R1 to be at high risk for falls with an intervention to monitor the resident at regular intervals. E3 (care plan coordinator), E11 (nurse) who completed the nursing assessment upon admission , and E 9 (nurse) who completed the fall assessment on admission were queried as to how the facility planned to monitor this resident. The facility did not have a specific plan on how or when to carry out the monitoring at regular intervals for R1. Review of the facility's assessment for R10 found this resident to be alert and oriented. This was	F 279		

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F 279	Continued From page 4 verified through interviews with E3, E8, E9, and E11. R10 has a diagnosis and history of urinary retention. The care goal was for R10 not to develop complications with a plan to assess drainage every shift, record amount, type, color, measure output. There was no documentation on the medication administration record, nurses notes, or elsewhere that the facility was following this plan for R10. The nurses notes for R10 document at 2 p.m. on 8/17/09 that the indwelling urinary catheter was discontinued due to penial swelling....continue to monitor. The next documentation in the nurses notes document at 12:15 a.m. on 8/18/09. 10 hours after the catheter was removed was...R 10 complained of pain genital/bladder and unable to void since 6 p.m.. R10 was found to have a distended bladder. A catheter was inserted and 800 cc of urine was obtained. The facility did not have a plan for the monitoring of R 10's urine/bladder function once the catheter was removed.	F 279		