STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145058	A. BUILDING _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-CHILLICOTHE	1028 HILLCREST DRIVE CHILLICOTHE, IL 61523

(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 Original investigation of complaint 1520785/IL74975.	F 000		
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: Based on interviews and record reviews the facility failed to remove wet gloves during dressing. One of three residents sampled (R1) was accidentally elbowed in the left cheek during cares. Findings include: R1's Occurrence Report, dated 2/14/15, notes that during "Dressing", "Resident (R1) is contracted and while trying to change residents top, resident pulled away from CNA. (E3 Certified Nurse's Aide) Due to the way the CNA was holding residents arm, CNAs arm slipped and elbow hit resident in the left orbital area." On 2/17/15 at 10:45 A.M. E3 stated that on 2/14/15 around 1:30 A.M. E3 was providing incontinent care to R1. E3 stated after performing incontinent care, E3 was changing R1's shirt. E3 stated that R1 is very contracted and when E3	F 323		3/14/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145058	A. BUILDING _____ B. WING _____	C 02/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-CHILLICOTHE	**1028 HILLCREST DRIVE CHILLICOTHE, IL 61523**

(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 323	Continued From page 1 was trying to hold R1's arm up, E3's hand slipped off R1's arm. E3's left elbow then hit R1 in the left cheek. E3 stated that her hand that slipped still had a wet glove on it and that she probably should have changed to a dry glove prior to attempting to dress R1. On 2/15/15 at 12:20 P.M. R1 was noted in wheelchair in dining room. R1 had a large greenish-purple bruise on her left cheek. On 2/15/15 at 12:05 P.M. E1 (Administrator) stated that E3 should have changed her wet gloves prior trying to dress R1. When E1 was asked for the Neuro (neurological) checks for R1, E1 stated that the staff did not do neuro checks as per facility policy. Facility policy for Head Injuries states, "a) Full set of vital signs and neuro checks every 15 mins (minutes) for one hour. b) Full set of vital signs and neuro checks every hour x 4. c) Full set of vital signs and neuro checks every 2 hours until completion of first 24 hours post injury. d) Full set of vital signs and neuro checks every shift x 72 hours."	F 323		