STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146100	A. BUILDING _____ B. WING _____	01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER NURSING HOME	**530 EAST BEARDSTOWN STREET VIRGINIA, IL 62691**

(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 SS=C	Annual Certification 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's abuse prevention policy failed to address that the Administrator is to be notified immediately of any allegation of potential abuse. This has the potential to affect all 46 residents in the facility. Findings include: The Abuse/Neglect Prevention Policy, documents "a staff person who observes or suspects abuse, neglect, or theft of property shall immediately report the matter to the Abuse Coordinator or Abuse Prevention Committee." Abuse investigations dated 10/13/11, 10/23/11, and 12/18/11, document E7 (Abuse Coordinator/Social Service) was immediately notified by staff of the allegations of potential abuse. On 1/4/12 at 10:05 a.m., E7 (Abuse Coordinator/Social Service) stated all allegations of potential abuse are reported to E7 or a member of the Abuse Prevention Committee which includes the Administrator.	F 226		

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 A Resident Census and Condition report completed by E8 (Care Plan Coordinator) on 1/3/11, documents a census of 46 residents.	F 226		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to have procedures in place for estimating water volume required and method for distributing water. This has the potential to affect all 46 residents in the facility. Findings include: Facility's undated emergency water policy states "(facility) keeps approximately 15 - 5 gal containers of water kept at storage shed 2 blocks away from facility." The facility's disaster emergency policy states the local fire department will be "furnishing drinking water." These policies do not address both potable and non-potable, method for distributing water or for estimating the volume of water required. On 1-4-12 at 3:30 pm, E4 (Assistant Administrator) stated these were the only policies the facility has related to provision of water.	F 466		

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F 466	Continued From page 2 The facility Census and Condition of Residents completed by E8 (Care Plan Coordinator) dated 1-3-12 shows there are 46 residents in the facility.	F 466		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to keep handrails firmly secured to the wall and free of splintering on two of three hallways (East and North). This has the potential to affect ten of 12 residents on the sample of 12 (R1, R3-R11), and 32 residents on the supplemental sample (R13-R44). Findings include: On 1-04-12 at 10:25 a.m. two areas of loose handrail were noted on the North and East hallways. The handrail on the East hallway was rough with some splintering. E16 (Maintenance Supervisor) and E4 (Assistant Administrator) stated at the time of observation they were unaware the handrails were loose and with rough areas. The facility's Census and Condition of Residents data sheet dated 1-03-12 and signed by E8 (Care Plan Coordinator) documents there are currently 46 residents in the facility. A resident log provided by E8 (Care Plan Coordinator) indicates that 42 of the 46 residents (R1, R3-R11, R13-R44) are independently ambulatory or use	F 468		

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F 468	Continued From page 3 assistive devices for ambulation and may use the handrails for support.	F 468		