PRINTED: 10/03/2005 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION					(X3) DATE SURVEY COMPLETED	
			A. BUILDING				C			
		14607	79	B. WIN	B. WING			7/2005		
NAME OF PROVIDER OR SUPPLIER						EET ADDRESS,		ZIP CODE		
HELIA HEALTHCARE OF CARBONDALE						00 SOUTH LEV ARBONDALE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEEDED SC IDENTIFYING INFOR	BY FULL	ID PREFI TAG		(EACH COR	VIDER'S PLAN (RECTIVE ACTIC D TO THE APPI	ON SHOULD I	BE CROSS-	(X5) COMPLETION DATE
F9999	FINAL OBSERVAT	IONS		F99	999					
FORM CMS.2	LICENSURE VIOLA 300.1210a) The facility must proservices to attain or practicable physica well-being of the reeach resident's complan of care. Adequates and personal care need	ovide the necessar maintain the high I, mental, and psycesident, in accordant prehensive assessuate and properly ersonal care shall meet the total nurses of the resident.	est chosocial nce with ssment and supervised be provided sing and	Fa	cility	D: 6016166		If conti	nuation shoop	t Pogo, 6 of 10
FORM CMS-2:	567(02-99) Previous Versions	s Obsolete	Event ID: 2THN11	Fa	cility)	D: IL6016166		If conti	nuation shee	Page 6 of 10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146079				ULTI LDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		146079	B. WIN	IG _		C 07/27/2005	
NAME OF PROVIDER OR SUPPLIER HELIA HEALTHCARE OF CARBONDALE				5	REET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH LEWIS LANE CARBONDALE, IL 62901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD I REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F9999	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F99	999			

Event ID: 2THN11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/27/2005	
		146079	B. WIN				
NAME OF PROVIDER OR SUPPLIER HELIA HEALTHCARE OF CARBONDALE				5	REET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH LEWIS LANE CARBONDALE, IL 62901	, 01721	72000
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F9999	-24-05, R1 is an 86 diagnosis includes Condition. R1 was 05. Per interview w DON) on 07-21-05 had told staff when the R1 had attempt that he had been a the facility. A wandering asses was completed for that R1 is ambulate symptoms of deme exhibited wandering days. The wandering or care planned wh 25-05 was complete who said that when her opinion too sick. Physical therapy as 27-05 show that R1 sitting independent assist to ambulate come from sit to stath that R1 can ambulate come from sit to stath R1 can ambulate can a	hysicians order sheet dated 06 year old male, his medical Senile Organic Psychotic admitted to the facility 06-24-ith E2 (Director of Nursing/ at 9:30 AM, R1's daughter he was admitted to the facility ed to elope from the hospital patient prior to admission at sment dated 06-25-05 that wandering behavior shows by with assistance, has not a confusion and had gobehaviors in the past 60 ng behaviors were not tracked en R1's plan of care dated 06-ed. This was verified by E2 R1 was admitted he was, in a rand weak to wander.	F99	999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/27/2005	
		146079	B. WIN				
NAME OF PROVIDER OR SUPPLIER HELIA HEALTHCARE OF CARBONDALE				5	REET ADDRESS, CITY, STATE, ZIP CODE 00 SOUTH LEWIS LANE CARBONDALE, IL 62901	01121	172003
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS-	(X5) COMPLETION DATE
F9999	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F99	999			

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/27/2005	
		146079	B. WIN				
NAME OF PROVIDER OR SUPPLIER HELIA HEALTHCARE OF CARBONDALE				50	REET ADDRESS, CITY, STATE, ZIP CODE OO SOUTH LEWIS LANE CARBONDALE, IL 62901	01121	172003
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SHOU TAG REFERENCED TO THE APPROPRIAT		BE CROSS-	(X5) COMPLETION DATE
F9999	(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F99	999			