STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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 520	Continued From page 60 records, the faciltiy has had an increase in falls in July (35 falls) and August (36 falls) following their restraint free change. On 9/3/09 at 9:50am, E1, Administrator was asked about whether the facility had identified an increase in falls since the changes and said they had not noted it until this past weekend after fall concerns were brought to their attention. On 9/1/09, it was noted there was no documented inservicing or training to direct care staff related to falls during the prior year.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)3) 300.1210b)6) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 3) Objective observations of changes in a resident's condition, including mental and	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 61 emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements are not met as evidenced by: A) Based on record review and interview, the facility failed to prevent falls for four (R5, R7, R12 and R17) of 17 total sampled residents and one off sampled resident (R26). The facility had no established measures or practices in place, or had ineffective measures and practices in place. that would have prevented the falls or limited the resident's injury. Interventions that were implemented were not evaluated for effectiveness, modified and/or replaced. These failures resulted in: (1) R7 had 30 falls between 10-08 and 8-26-09 with a fracture occurring on 8-9-09. (2) R12 fell and had a fracture of the shoulder and tibia. (3) R17 fell 10 times between 1-30-09 and 8-20-09 and had a left hip fracture. (4) R5 fell 5 times between 4-19-09 and 7-20-09.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 62 (5) R26 fell 16 times from January 2009 through August 2009, 10 were at night. Findings include: 1. R7's Minimum Data Set (MDS), dated 5-2-08 and 7-1-09, documented that R7's cognition was severely impaired with short and long term memory problems and that R7 required extensive staff assistance of at least one person physical assistance with mobility, ambulation, transfer and toileting. R7's Care Plan, onset date 5-15-08, documented that R7 was at risk for falls. Review of the facility's 2008-2009 Timeline provided for R7's falls, documented that R7 fell on 8-18-08 which resulted in a left hip fracture. The facility's 2008 Incident log, dated 10-08 to 12-31-08, documented that R7 had 20 additional incidents of falls and 2 incidents of skin tears after her 8-18-08 fall, of which R7 fell with her alarm sounding on 10-5-08, 10-14-08 and 11-7-08. The facility's 2008-2009 Timeline and R7's 2009 Incident Reports documented that R7 fell in 2009 on 1-2-09, 1-12-09, 2-9-09, 5-1-09 with her alarm sounding, on 5-17-09 with her alarm sounding and on 8-9-09. R7's Nursing Notes, dated 8-9-09 at 2110, documented that R7 was found on the floor with a small skin tear, with bruising, on her left hand, first finger and that she was taken to the nursing station for observation. R7's Nursing Notes further documented that R7 complained of right hip pain at 10:30p.m. and that she was transported to a local hospital. The local hospital's Radiology Report, dated 8-10-09, documented that R7 had a fracture of the proximal right femur and a fracture of the inferior	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 63 and superior pubic rami. Since R7's 8-9-09 fracture, the facility documentation documented that R7 fell, at times found scooting on the floor, on 8-15-09, 8-25-09 and 8-26-09. The facility's 2008-2009 Timeline, R7's Incident Reports and Nursing Notes, did not consistently document that the facility had assessed what contributing factors were present prior to R7's falls to assist in assessing what possible interventions and/or measures might have been effective in preventing R7 from experiencing continued falls. The facility provided a Fall Risk Assessment and Safety/Risk Assessment Plan, dated 8-29-09, which documented a plan of identification of hazards/risks, evaluation/analysis of hazards/risks, implementation of interventions and monitoring/modification of interventions to address R7's further falls. 2. According to the Admission sheet, R12 is an 87 year old female originally admitted to the facility on 6/12/06, with the most recent admission date of 3/29/09, with diagnoses of Hypertension, Left Proximal humerus fracture 5/12/09, and chronic pain. Review of the MDS dated 6/12/09 identifies R12 as having short/long term memory deficits with moderate cognitive impairment, and requires extensive assist of two persons physical assist for bed mobility and transfers. The MDS indicates R12 does not walk in room or corridor and requires extensive assist of one staff for locomotion on and off the unit. The MDS further indicates R12 requires physical help for standing balance. The MDS indicated R12 had falls within	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 64 30 days of this assessment and a fracture within 180 days of the MDS. Under devices and restraints used, only side rails are identified. Review of the care plan dated 4/15/09 indicates under SAFETY NOTES/FALLS that R12 is at risk for falls, staff are to keep her call light within reach, keep bed at lowest position when she is in it, observe her sitting position and keep her safe, keep room free of clutter and tabs alarm as an audible reminder to her and staff that she is moving and needs assistance. The goal is to have no falls or serious injuries from falls. Under the care plan section entitled MOBILITY, it states she moves around in her wheelchair, walks only with skilled therapists with wheeled walker and gait belt, built up shoe on left foot, and transfers with 2 CNA's (Certified Nurses Aides). This section indicates side rails are used to assist her in helping to pull up in bed. Written in on this section of the care plan is a statement what reads, "I recently fell and fractured by left arm. I have a sling/immobilizer on all the time and cannot use the arm" and "I am propelled by staff to all destinations in my w/c (wheelchair)." Further review of the clinical record indicates R12 sustained a fractured left humerus from a fall 5/12/09 and then sustained a fractured tibia in a fall on 7/22/09 which was not identified until 7/28/09. Review of R12's FALL RISK ASSESSMENTS show the most recent being undated with 9 checkmarks present. The coding for the risk assessment indicates a score of 10 or greater indicates the resident is at risk and care planning should follow. According to the INCIDENT/ACCIDENT LOG, R12 had no prior falls back to January of 2009. On 5/9/09 at 6:50pm, R12 was found in lobby	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 65	F9999		

lying on her left side stating she was transferring herself from the chair to the wheelchair. The report indicates she complained of left shoulder soreness but AROM/PROM (Active range of motion/passive range of motion) was within normal limits at the time of the incident. The report further states her left shoulder had a large amount of swelling. R12 also sustained a left temple skin tear/laceration in the fall. R12's POA (Power of Attorney) and physician were notified and she was transferred to the emergency room where the humerus fracture was discovered and treated with surgical intervention.

Review of the INCIDENT REPORT FOLLOW-UP dated 5/11/09 stated R12 fell in the center lobby area as she attempted to transfer herself unassisted to a reclining chair. The report and the original incident report fail to include whether R12 had her TABS alarm on or not and failed to determine what the causative factor was in her fall.

R12 returned to the facility on 5/10/09 with a cast on her left arm. There is no evidence the facility reassessed R12 at the time of her readmission to determine if her current interventions were appropriate and effective. Review of the care plan fails to show any revisions to the falls prevention plan. A falls risk assessment completed upon return again identifies her at a "9" which is not considered a fall risk by the facility although they did care plan safety and falls.

According to the nurses notes, on 7/22/09 at 1:30am, R12 was "found lying on floor between roommate and res (resident) bed area. When asked res "I had to get up." was confused at time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 66 of incident...did not sustain any visible injuries, c/o knee pain." At 11:45am R12 was unable to bear weight and the physician was notified. A portable Xray was ordered which was negative. The nurses notes further state on 7/28/09 at 9:45am, R12 was out to physician with POA and returned with a diagnoses of Left Tibia fracture. According to interview with Z1, R12's POA/Family member on 8/27/09 indicated that R12 had had an alarm since admission until she noticed about 1 1/2 weeks prior to her first fall and shoulder fracture that it had been discontinued. Z1 stated she was not made aware that the facility discontinued it and was told by the nurse when she asked that the "facility went restraint free" and the "government said residents had the right to fall." Z1 stated the facility did not reinstate the alarm following the first fall and she fell again fracturing her knee a couple months later. Review of the nurses notes confirm that Z1 questioned the facility on the lack of alarm for her mother on 7/30/09 at 10:30am. The nurses notes entry states "called (Z1) to discuss families worries concerns regarding res fall resulting in Fx (fracture) of L (Left) tibia Plateau. Family concerned c (with) removal of alarm. I discussed c daughter that alarms would not prevent falls that the noise of alarms sometimes agitates res and raised to noise levels in there home." The note continues to state Z1 would feel more comfortable with alarms on and the writer stated they would be reinstated. The facility has no evidence R12 was assessed for the effectiveness of the alarm in preventing her from falling prior to the first fall when the alarm was discontinued. Interview with E6, LPN (Licensed Practical nurse/nurse manager) on	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 67 8/28/09 1:46pm indicated R12 had poor safety awareness and does not understand what you say to her, and added that R12 had a "memory problem." E6 stated R12 did not have an alarm on at the time of the first fall as it had been removed. E6 said the alarm was removed because she was setting it off all the time, although E6 stated the facility did not document how many times the alarm went off. E6 stated that the alarm did not keep R6 from standing up prior to her first fall and after that, she did not attempt getting up. When asked again if R12 was assessed for additional safety interventions, E6 stated they "would not assess her for anything more restrictive, it causes more harm... they don't understand what you're doing." E6 stated she did discuss with the daughter about siderails and the "daughter wanted the alarm back on" but she explained that the alarm wouldn't prevent her from falling." E6 stated E14, LPN, was the "keeper of the alarms." Interview with E14 on 8/28/09 at 3:45pm indicated that no assessment was present for R12 that reflected the use of the alarm, the effectiveness of the alarm and why the facility determined it was appropriate to discontinue its use. E14 stated R12 was "notorious for disalarming it" and that the alarm "irritated her" adding that R12 is "very impulsive" and the alarm "did not make her sit back down." E14 did state the facility attempted a "TABS" monitor and pressure alarm but did not feel at the time that it was a benefit to her. E14 stated other interventions were in place for falls prevention that include keeping her within visual range, toileting program of every 2 hours, if restless move to recliner at night and occupy/engage her. E14 was asked about R12's first fall occurring in	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 68 the lobby area and stated she started to fall but staff could not get to her in time. The second fall occurred out of bed. There is no evidence the facility took either of these falls and there circumstances into account when developing a plan of care for falls prevention. E14 was asked if she knew if R12's alarm ever went off and how many times. E14 responded she did not need to know that because she monitored if it was effective and beneficial. E14 was asked if an alarm was effective if it caused the resident to stop, sit back down and wait for staff, to which E4 stated "yes, I would say that was effective." Interview with several direct care staff on 8/28/09 conflicted with information provided from E14 and E6 in regards to the effectiveness of the alarm use for R12. On 8/28/09 at 1:15pm, E16, CNA supervisor for R12's hall was asked about her alarm and stated R12 did set off her alarms, more in the evening after family leaves. E16 stated she would try to get up 1-3 times in an evening and he did not recall the alarm causing agitation. At 1:30pm E15, CNA, was asked about R12's alarm use and stated R12 does try to get up unattended and will be found sitting on the side of the bed. E15 stated R12 had an alarm on until June and it was discontinued while she was off work on leave. E15 described R12 as "cooperative with care but says no." At 3:27pm on 8/28/09, E18, CNA was interviewed and stated she was primarily scheduled on R12's hall. E18 stated R12's alarm used to go off but stated no particular time. E18 stated R12 currently has an alarm because the daughter requested it. When asked if R12 continued to attempt to stand up unassisted, E18 stated "not since this last fall."	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 69 On 8/28/09, E17 CNA was interviewed due to her being a primary care giver for R12 on second shift. E17 stated R12 used to set off the alarm and "she sat right back down." E17 also stated "when she pushed herself up, alarm would go off and she'd sit back down." E17 estimated that R12's alarm would go off 1 time a shift. E17 stated the facility took off all the alarms while she was on vacation and she was unsure as to why. E17 stated the CNA's do not document how many times an alarm goes off nor had anyone talked to her about R12's alarm use in regards to the number of times it went off and whether or not it was effective. E17 stated the "alarm helped them (CNAs) and her (R12) because she'd sit back down." Information provided to the surveyors on 8/29/09 regarding R12's falls indicates R12 currently has a bed/chair alarm and her plan of care for falls has been updated. Review of the facility's FALLS PREVENTION POLICY indicates the facility's primary goal is to provide a safe environment for the residents. The policy indicates each resident will have the following in an effort to prevent a fall. 1) Each resident will be assessed upon admission by the therapy department, who will then determine the safest way to transfer a resident. 2) When the resident is in their room, staff will insure that their call light is within easy reach and 3) Staff will continually monitor the resident's room as well as common areas to help insure that potential environmental hazards are eliminated as much as possible. The policy continues to state that residents will be assessed following a fall and the IDT (interdisciplinary team) will make appropriate recommendations/follow-up/interventions for that	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 70	F9999		

particular resident. The policy fails to include the need for a comprehensive assessment by nursing that assesses both the cognitive and functional ability of each resident along with the causative factors that puts that particular resident at risk. There is no indication the facility policy addresses the resident's need for adequate supervision and/or safety devices to prevent falls.

3. Record review of R17's Minimum Data Set, MDS, of 7-23-09 shows R17 was admitted to the facility on 1/30/09; has severe cognitive impairment; requires limited assistance of 1 for bed mobility; extensive assistance of 1 for transfer, ambulation, hygiene and toilet use. MDS shows R17 has a history of falls and is not able to attempt standing without physical assistance.

R17's Care Plan of 2-16-09 and 5-11-09 states, "Safety Notes/Falls:" Risk for falls. Keep call light and necesseties within reach. Keep bed in lowest position. Keep room free of clutter. Stay with resident in the bathroom. Care plan of 7-28-09 show the same above interventions with addition to keep the bed against wall.

Nurses Note of 1-30-09 show R17 was admitted to the facility with a right hip fracture with pinning and a closed head injury.

Nurses Note of 1-31-09 states R17 was being transferred by a CNA and R17 started to slide down so she was lowered to the floor. There is no FALL RISK ASSESSMENT or RESIDENT INCIDENT REPORT showing that the facility identified or assessed risk factors that would result in R17 being lowered to the floor. There is no assessment as to whether R17 was being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 71 transferred by 1 or 2 CNA's or if a gait belt and/or proper technique was used during the transfer. R17's FALLS RISK ASSESSMENT of 2-4-09 shows R17 had a fall prior to admission with a fracture of the right hip and intercranial bleed. Assessment states no falls since admitted to the facility. Yet Nurses Note of 2-3-09 at 5:25AM states R17 had attempted to use the bathroom and fell out of bed and was lying on her left side. Nurses Note of 2-4-09 at 11:00AM states R17 was climbing out of bed at night between 2:00AM and 4:00AM, falling twice. The note states the nurse was requesting Ambien. FALLS RISK ASSESSMENT of 2-11-09 states no falls this period. (There is still no assessment of R17 being lowered to the floor, attempting to crawl out of bed or the 2 falls on 2-4-09.) The next FALL RISK ASSESSMENT of 3-26-09 states fall on 3-16-09 - no injuries...(There is no assessment as to where, when, why or how R17 fell.) Nurses Notes of 3-16-09 at 6:50AM state R17 climbed out of bed without assistance and landed on the floor on her buttocks with lower extremities extended. Nurses Note of 3-18-09 at 6:45AM again show R17 crawled out of bed without assistance. Found sitting on floor with legs extended and wet bed linens noted. (Again there is no assessment). Nurses Notes of 4-5-09 at 3:45AM state R17 was sitting on the garbage can urinating. R17 stated I can't have a bowel movement. Nurses Note of 4-12-09 states a CNA found R17 trying to get out of bed with shoes on, wrapped in blanket stating she needed to take her kids to school.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 72	F9999		

Nurses Note of 4-18-09 at 6:10PM states that staff reports to writer that R17 was observed on the floor in the dining room...No apparent injury noted other than a small amount of blood noted in resident's mouth. Two of resident's front teeth also noted to be missing. POA (Power of Attorney) notified and states that R17 has always had her front teeth. No front teeth found. RESIDENT INCIDENT REPORT of 4-18-09 is incomplete as to type of incident is left blank. Report states R17 was observed on the floor by staff. Assessed by LPN (Licensed Practical Nurse). R17 brought to writer in wheelchair. Small amount of blood noted in R17 mouth with 2 front teeth noted to be missing. POA notified. POA states that R17 has always had her 2 front teeth. Writer notified him that teeth were not found. ROM WNL (range of motion within normal limits). No complaints voiced. Mouth rinsed with warm water. MD notified per fax. (There is no assessment as to how R17 fell, what interventions were being used to prevent falls or if interventions were effective.)

RESIDENT INCIDENT REPORT of 4-22-09 shows R17 was again found lying on the Dining Room floor on her left side. Again there is no assessment or new interventions to prevent falls.

Nurses Notes show R17 was found on the floor in her room on 5-14-09 at 6:15AM with urine on the carpet. Note of 5-16-09 at 11:00AM states R17 remains quite restless today and requires frequent reminders to wait for staff with getting up. Alarm in place. There is nothing in her Care Plan addressing the use of an alarm or an assessment of the use of an alarm or if the alarm was an effective intervention. Nurses Note of 7-12-09 again show R17 was found on the floor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 73 in her room. Note stated R17 was put in a wheelchair with a pommel cushion. Again there is no assessment for the use of a pommel cushion and its effectiveness. There is nothing on the Care Plan addressing the pommel cushion. Nurses Notes of 7-21-09 at 3:15PM state R17 stood up from recliner and had hands on walker and tripped over a wheel chair in walking path and fell to the floor. Nurses Quarterly Note of 7-22-09 states R17 is occasionally impulsive and will try to get up and walk without assistance. Note at 7:39 states R17 was noted to be attempting to stand up from recliner. Note of 8-19-09 at 10:00PM states R17 was found sitting in the bathroom doorway. Nurse Note of 8-20-09 at 6:45PM states R17 was found on the floor in the Dining Room. (This was the 3rd time R17 had gotten up from the Dining Room chair and fallen.) Nurses Note of 8-21-09 at 6:50AM states R17 was unable to ambulate and her left leg was noted to be outwardly rotated and R17 complained of hip pain. Note at 20:22AM states R17 was admitted to the hospital for a left hip fracture. Interview with E1, Administrator, on 8-28-09 confirmed R17 had stood up from the Dining Room chair and had fallen 3 times with the 3rd time resulting in a fractured left hip. On 9-1-09 at 11:50AM, E20, CNA, stated R17 had tried to get up that morning. E20 stated R17 was sitting up with her legs over the side of the bed. The alarm did not go off. E20 stated the alarm does not work when its set on low. Observation shows R17's room is at the end of the hallway and the farthest room from the Nurses station. 4. According to the admission sheet, R5 is a 92 year old female admitted to the facility on 9/26/06 with diagnoses of Hypertension, Osteoporosis,	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 74 Peripheral Neuropathy, history of falls with subdural hematoma in 2008, and Chronic pain among others. Review of R5's MDS dated 6/11/09 identifies her to have short term memory loss with impaired decision making skills. The MDS indicates she requires extensive assist of one staff for all transfers, bed mobility and ambulation. The MDS indicates R5 has a standing balance deficit and is unable to perform task without assistance. Review of the care plan dated 6/23/09 identified R5 as being at risk for falls with interventions including keeping the bed in lowest position when she is in it, observe her sitting position and intervene as needed to keep her safe and keep her room free of clutter, among others. The goal is to keep her fall free or have no serious injuries from falls. Review of the RESTRAINT/SIDE RAIL ASSESSMENT dated 3/18/09 indicates R5's recovery balance is fair in wheelchair and she has two side rails. The FALLS RISK ASSESSMENT dated 1/14/09 has a score of 14 placing her at high risk. The narrative states "poor safety decision making... not always calling for/waiting for assistance. Uses alarm to alert staff when in bed. Uses 2 side rails for T&P (turn and position), can walk short distances c (with) w (wheeled) walker + hands on assistance, but has poor endurance. Balance deficits present. See MDS for scores. Remain at risk for falls." According to the INCIDENT LOG, R5 fell on 4/19/09. The report indicates it was at midnight and resident was found sitting on floor by side of	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 75 bed stating she was getting up to go to bathroom when her foot got caught behind wheel on wheelchair. R5 sustained a small abrasion area on her right buttock. There is no indication R5 had the body alarm on, the bed was in its lowest position, whether the side rails were up or if her call light was within reach as indicated in her plan of care for falls prevention in an effort to determine whether the interventions were effective or not. There is no indication R5, with her short/long term memory deficits, is capable of using the call light appropriately. According to interview with E19, LPN and nurse manager for R5's hall, R5's alarm had been discontinued and she currently uses only one side rail. There in no indication as to when those interventions were discontinued or why, and no evidence the care plan was revised to show these changes. On 5/8/09 at 9:30am, R5 was reported to have fallen while transferring herself to the bed from the wheelchair. Again, there is no indication the facility reassessed R5's fall for effectiveness of interventions and whether a revision was necessary in an effort to prevent R5 from falling again. No further assessments were done until 6/10/09 which states "R5 fell this week trying to take herself to the bathroom. She has poor decision making. She has balance deficits more standing than sitting. She has decreased strength and endurance. She remains at risk for falls." There is no evidence the facility reassessed R5 at that time in an effort to prevent further falls. On 6/11/09 at 9:35am, R5 fell again during a self transfer with assistance from the wheelchair to the bathroom. The fall was not witnessed. She sustained a small hematoma on back of her head. Again, no evidence the facility evaluated	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 76 the fall to determine the effectiveness of the interventions if they were implemented. On 7/20/09 at 10:00am, R5 attempted to transfer herself from the recliner to her bed and fell to the floor when she lost her balance. There is no indication the facility reassessed R5's needs and revised her falls prevention plan in an effort to prevent further falls. On 8/28/09 at 10:20am, E19 stated staff have learned from R5's falls that they need to put her down as soon as she returns to her room, that she tends to not wait and will not turn on the call light. The is no assessment present that indicates when the staff determined this and why. In addition, there is no evidence R5's plan of care was revised to include these interventions. On 8/29/09, the facility reassessed R5 and revised her plan of care for falls prevention. Under EVALUATION/ANALYSIS OF HAZARDS/RISKS, it states R5 "forgets to use her call light to request assistance, resident has climbed around rails as well as putting it down in an attempt to transfer independently, resident does not wait for staff when she does recall need to use call light, resident is very impulsive and tends to do what she wants to do." There is nothing under this section that supports E19 stating R5 wants to go right to bed when she gets back to her room. However, under implementation of interventions, it does state "staff should assist her to the bathroom and with any other personal care matters prior to lying down to help eliminate attempts to transfer independently." Another intervention added read "staff need to make a note to glance in her room as they pass by to be sure she is not trying to get	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	180 WEST IMBODEN DECATUR, IL 62521

(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
F9999	Continued From page 77 out of bed without assistance." Throughout the survey, R5 was observed either in her wheelchair at meals or in bed. When in bed, R5's bed was not in the lowest position. She had one rail only on the wall side of the bed and her curtain between the beds was pulled at all times when she was in the bed making the intervention to glance into her room as you pass by questionable as being effective. 5. Record review of R26's 8-6-09 MDS shows she requires extensive assistance of 1 for transfer, ambulation, hygiene and toilet use. MDS shows R26 fell in the last 30 days and not able to stand without assistance. Care Plan of 9-4-08 identifies R26 as being at high risk for falls. Care Plan states R26's family and R26 were educated regarding redirection of unsafe acts - poor judgements regarding safety. Monitor medication action side effects and possible interactions; monitor and redirect behaviors; ensure she has shoes on to ambulate; wheelchair as needed related to strength abilities fluctuate; encourage activities; check for incontinence every 2 hour; redirect unsafe acts and non use of walker. R26's RESIDENT INCIDENT REPORT's show R26 fell or was found on the floor 16 times between January 1-11-09 and 8-29-09. Reports shows 9 of these falls happened between 11:15PM and 4:55AM. There is no assessment as to 9 falls in the early morning hours or new interventions to prevent falls/injuries. On 9-1-09, E1, Administrator, was informed of concern of R26's repeated falls with lack of	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145945	A. BUILDING _____ B. WING _____	09/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMBODEN CREEK LIVING CENTER	**180 WEST IMBODEN DECATUR, IL 62521**

(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
F9999	Continued From page 78 assessment and interventions. (A)	F9999		