		I AND HUMAN SERVICES			FORM	APPROVED		
	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	MB NO. 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		146059	B. WI	NG _		09/1/	6/2011	
NAME OF F	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
HERITAC	GE HEALTH-JACKSO	NVILLE			873 GROVE STREET			
					JACKSONVILLE, IL 62650			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	rs	F	000				
	Annual Recertificat	tion and Licensure						
	Complaint Investiga 1142786 (IL 54445)	ation) - F157, F309, F323						
F 157	Barton Stone is in s Subpart U: 77 Illino 300.7000 483.10(b)(11) NOT		F	157	,		10/16/11	
SS=D	consult with the resknown, notify the resort an interested fam accident involving trinjury and has the printervention; a signiphysical, mental, or deterioration in heat status in either life trinical complication significantly (i.e., a existing form of treat consequences, or treatment); or a determent); or a determent); or a determent from th §483.12(a). The facility must als and, if known, the roor interested family change in room or president rights under	ediately inform the resident; ident's physician; and if esident's legal representative nily member when there is an he resident which results in potential for requiring physician ificant change in the resident's psychosocial status (i.e., a lth, mental, or psychosocial threatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge he facility as specified in so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 02/25/2012

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.

		AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		146059	B. WING	·	09/10	6/2011
NAME OF P	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE 873 GROVE STREET		
HERITAC	GE HEALTH-JACKSO	NVILLE		JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 157	Continued From pa this section.	ge 1	F 15	57		
	the address and ph	cord and periodically update one number of the resident's or interested family member.				
	by: Based on interview review, the facility fa physician or family for 2 of 26 residents	NT is not met as evidenced vs, observations, and record ailed to immediately notify the member of a condition change s (R25 and R2) reviewed for /or physician in a sample of	[
	Treatment Plan of pressure sore on R stage 1 "Non-blanc skin or warmth/ede Size: length; 3 wid undated note under documentation, "DT heel, waffles to feet brown, boggy et inta skin prep order." O (Treatment Nurse) note concerning DT Treatment Administ Physician Order Sh not get a treatment order was obtained Allevyn heel dressir Record review of Treatment Plan from	of R2's ULCER Care Plan - 8-15-11 documents a 2's left heel with an "X" next to hable erythema, discolor dark ma/induration. Skin intact. Ith: 2.5 Drainage: none" An r Initial Entry Note: had TI (deep tissue injury) to L (left t, et (and) floated, area dark act. Dr (Doctor) updated for 0n 9-16-11 at 11AM, E13 stated she had written the TI on 8-18-11. (R2's tration Record (TAR) and leet (POS) show the facility did order until 8-22-11 when for skin prep and cover with ng and Kling. f R2's ULCER Care Plan - m 8-15-11 through 9-15-11 he pressure sore with no				

Facility ID: IL6000756

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FORM	: 02/25/2012 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION	(X3) DATE S COMPLE	
	146059	B. WING	IG	09/1	6/2011
NAME OF PROVIDER OR SUPPLIER		;	STREET ADDRESS, CITY, STATE, ZIP COD	E	
HERITAGE HEALTH-JACKSONVI	ILLE		873 GROVE STREET JACKSONVILLE, IL 62650		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE
F 157 Continued From page		F 1	57		
 documentation marked (Doctor Notification) un During interview with 3:45PM, E19 stated sh heel. E19 stated when it was a blister. E19 st with brown dried edges the dressing every nigh week the blister broke skin prep (Sureprep) to seem to be improving stated she felt the skin the pressure sore was treatment needed to be September 11, 2011, s know so the Physician Nurses Notes of 9-1 R2's Physician was fax to treatment to left hee provided by E21, Corp Communication form of to R2's Physician docu order for skin prep L he we DC (discontinue) of cleanse dly (daily with wash, apply silvasorb g with foam pad et wrap signed with OK and se 9-15-11 at 1431. R25's nurses notes 11:53pm documents th Aide) reports reposition resident up in bed c (w right upper arm to pull tear" measuring 4cm x The notes document th 	d under section "Dr. Notif" ntil 9-15-11. th E19, LPN, on 9-15-11 at he does treatments to R2's n she first saw R2's left heel tates its now real beefy red es. She said she changes th when she works. Last and they were still using to the heel. The heel didn't over the weekend. E19 n prep was not working and s getting worse. E19 felt the be changed and on Sunday, she let the night Nurse n could be notified. 14-11 at 2325 document xed an update with regards el - no improvement. A Fax borate Nurse, showed a Fax dated 9-15-11 at 0730 sent umenting R2 "has current heel. Area now open can current order et change to normal saline or wound gel to open area Cover o with kerlix?" The Fax was ent back to the facility on as written on 8/28/11 at hat "CNA (Certified Nurses poing in bed - pulling with) his assist - grabbed up in bed - received skin x 2cm in half moon shape.				

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	URVEY
		146059	B. WIN	1G		09/1	6/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE HEALTH-JACKSO	NVILLE			73 GROVE STREET ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 157 F 309 SS=D	family member, pownotified of the injury On 9/13/11 at 2: and Power of Attorr unaware of the skin expired on 8/31/11. that he had injuries, Record review s wound specialist for however, pictures a having steri strips o evidence present in R25's POA was infor As of 3pm on 9/ provided no evidence family on either the skin tear. 483.25 PROVIDE OF HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho accordance with the and plan of care. This REQUIREMEN by: Based on interview review, the facility fa assess/monitor and	Wer of attorney (POA) was Wer of attorney (POA) was 30pm, r25's family member hey (POA), Z2, stated she was tear occurring until after he Z2 stated she was unaware Wounds on his feet. shows that R25 was seeing a r his right foot second toe, also show R25's left great toe on it as well. Again, there is no the clinical record that shows ormed on this injury/wound. 16/11, E2 Director of Nurses, ce of notification to R25's foot and/or the upper arm CARE/SERVICES FOR EING t receive and the facility must ary care and services to attain hest practicable physical, bsocial well-being, in e comprehensive assessment NT is not met as evidenced vs, observations and record		309			10/16/11

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		HAND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		146059	B. WII	√G		09/10	6/2011
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HEALTH-JACKSO	NVILLE			73 GROVE STREET IACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	Continued From pa	ige 4	F	309			
	an male age 88 adi with diagnosis of R Dialysis, Diabetes N Sheet (POS) for Au received Plavix 75 81mg daily along w The care plan da have skin issues in healing time possib of chronic Lymphoi disease with dialysi and anticoagulant & The care plan id on 8/22/11 left uppe 8/23/11 document s (left) axillary area u nurses notes dated R25 had "repots of shower with large b assessed 8in x 5.5i exceeding down et under armpit/breas made aware. No ne (Power of attorney) On 8/23/11, R25 the Plavix on hold of nurses notes fail to including continued either the hematuria and the effects of h According to the 8/31/11. Pictures p Director) show exter by 5.5 inch initially i picture showed dar	lentifies R25 to have a bruise er axilla. Interventions dated staff are to "monitor bruise to L intil healed." According to the l 8/22/11 written at 4:35pm, hematuria x (times) 1 during bruise on L side. Bruise in noted under I armpit et (and) back toward back. Tender t area to touch. MD called et ew orders received. POA aware." 's physician called and placed due to the bruising. The reflect any further information I monitoring/assessments on a and/or the extensive bruising					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 146059 09/16/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **873 GROVE STREET** HERITAGE HEALTH-JACKSONVILLE **JACKSONVILLE, IL 62650** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 309 Continued From page 5 F 309 down to his waist, under his left axilla towards his back with varying shades of bruising ranging from purple/blue/red to yellow/green. Z4 confirmed these photos were of R25. Evidence of monitoring/assessing this bruising was requested from E2, Director of Nursing on 9/16/11 with none being provided. 2. R1's Admission Nursing Assessment, dated 9-7-11, documented R1 was admitted from a local hospital with diagnosis, in part, of Alzheimer. It was also noted R1 was an extensive assistance with bed mobility, transfers and locomotion and deep rash to her entire buttock. R1's Wound Care Plan - Treatment Plan, dated 9-7-11, documented "excoriation/rash/dermatitis" of R1's entire buttock. R1's Wound Care Plan did not document measurements or specific areas of excoriation/rash/dermatitis. On 9-14-11 at 10:30a.m., E6, Certified Nursing Assistant (CNA) and E7, (CNA), were observed providing R1 with incontinent care. R1's buttock, coccyx and lower middle back were observed with well defined, deep red areas of irregular sizes, from 1cm x 1cm round to 4cm x 3cm oblong. On 9-15-11 at 8:50a.m., E9, Licensed Practical Nurse (LPN), was observed providing a treatment change to R1's right heel. R1 repeatedly complained of buttock pain during the observation and R1's buttock, coccyx and lower middle back were observed with well defined, deep red areas of irregular sizes, from 1cm x 1cm to 4cm x 3cm oblong. R1's chart and Wound Care Plan - Treatment Plan did not document assessment, monitoring or measurements of R1's buttock, coccyx and lower middle back until R1's 9-14-11 Wound Care Plan

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		AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		146059	B. WING		09/1	6/2011
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	-	
HERITAC	GE HEALTH-JACKSO	NVILLE		873 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309 F 314 SS=G	with 5.5cm x 2.0cm (left) inner ischial, 1 6.0c m x 2.2cm are scratches noted to on R1's lower midd E8, Alzheimer U 9-15-11, that meas coccyx and lower n 9-14-11. 483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the faci does not develop p individual's clinical they were unavoida pressure sores reco services to promote prevent new sores This REQUIREMEN by: Based on observar review, the facility f accurately assess, treatments for press for 3 of 5 residents for pressure sores resulted in R2 havin size in her pressure non-blanchable are	It was noted, in part, "noted excor (excoriation) area to (L) 1.0cm x 1.0cm area to coccyx, ea to (R) (right) ischial and (L) upper ischial area." Areas le back were not documented. Jnit Manager, stated on surements of R1's buttock, hiddle back were not done until MENT/SVCS TO PRESSURE SORES orehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and from developing. NT is not met as evidenced tion, interview and record ailed to consistently and monitor and implement new sure sores to prevent decline (R2, R3 and R14) reviewed in a sample of 26. This failure ng a decline and increase in e sore from purple	F 309	}		10/16/11
	with drainage. This	able pressure sore on her				

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		AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		146059	B. WING		09/10	6/2011
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE HEALTH-JACKSO	NVILLE		873 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ige 7	F 314	1		
	right trochanter that and treat until it was	t facility did not identify, assess s unstageable.				
	Findings include:					
		of R2's Admission Sheet of umentation that R2 was				
	readmitted to the fa	acility from the hospital with				
		ble area on her left heel. f R2's ULCER Care Plan -				
		8-15-11 documents a 2's left heel with an "X" next to				
	stage 1 "Non-blanc	heable erythema, discolor				
		n/edema/induration. Skin n; 3 width:2.5 Drainage: none"				
		nder Initial Entry Note: had				
		ΓI (deep tissue injury) to L (left to t (and) floated area dark				
		t, et (and) floated, area dark act. Dr (Doctor) updated for				
		On 9-16-11 at 11AM, E13 stated she had written the				
		FI on 8-18-11. (R2's				
		tration Record (TAR) show the				
		treatment until 8-22-11 when for skin prep and cover with				
		ng and Kling. This was 7 days				
	was assessed.)	identified and 4 days after DTI				
		ment of 8-25-11 on the				
		t Plan, shows pressure sore cm with <0.1 cm depth with				
		ous drainage and is red in tten with documentation:				
		, 100% red dermis, 0				
	undermining, 0 tuni TX"	neling cont (continue) current				
	The next assess	ment of 9-1-11 documents				
	pressure sore is 3 x	x 3 cm with superficial depth				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 146059 09/16/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **873 GROVE STREET** HERITAGE HEALTH-JACKSONVILLE **JACKSONVILLE, IL 62650** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 Continued From page 8 F 314 and no drainage and red in color. Note "100% red dermis heel protector in place cont current tx." The next assessment of 9-8-11 shows documentation that the pressure sore is 3.2 x 3 cm unstageable 0.1 black. Note states to continue same treatment. The next assessment of 9-15-11 shows documentation that pressure sore is 3 x 3 cm with <0.1 depth with scant serosanguinous drainage ane 0.8 x 0.5 red dermis and .4 x .6 black. Note documents Physician was notified on 9-15-11. R2 was observed on 9-14-11 at 10:10AM to be in bed and had an Allevyn heel and Kirlex on her left heel. E14, Licensed Practical Nurse (LPN) removed the dressing from R2's heel. The Allevyn heel was stuck to the wound and there was dark brown drainage. The pressure sore was beefy red with edges that were black in some areas. The beefy red area was a full thickness wound. E14 cleansed the wound with wound cleanser and gauze and then put R2's heel down on the pillow at the foot of her bed. E14 then opened a Sureprep wipe and wiped around and over the pressure sore. E14 fanned R2's heel until Sureprep dried and then placed a gauze pad in the same soiled Allevyn heel and placed the dressing on R2's heel. E14 was asked if she was using the same dressing that she just took off and E14 confirmed she had used the same Allevyn heel. E14 then stated maybe she shouldn't and took the dressing off R2's heel, took out the gauze pad and confirmed the Allevyn was soiled with brown drainage. E14 then placed R2's ankle on the pillow and told her not to let the pillow touch her heel. E14 left the room to get supplies and when she came back, R2 had rearranged her foot and the pressure sore was touching the

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		AND HUMAN SERVICES					APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		146059	B. WI	NG _		09/10	6/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HEALTH-JACKSO	NVILLE			873 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	pillow. E14 put a ne Allevyn heel, put the dressed with kling v pressure sore. On 9-15-11 at 10 was red when first a DTI. E13 confirmed change. E13 stated information to the D change the treatmen stated the pressure loss with partial bro that for about a wee According to the Sureprep, provided Sureprep is for mar to provide an addition around a wound du During an interview Z3, Certified Wound Sureprep, Z3 stated be used is to proted used on full thickne for full thickness los Record review of through 9-14-11 sh R2's Physician was pressure sore. Phy 8-22-11 through 9-1 change in treatmen pressure sore on th Nutrition Assessm admitted on 8-15-1 a DWR (desired we The Assessment sh and estimated intak documents general	ew gauze pad into a new e dressing on R2's heel and without re cleansing the D:25AM, E13 stated R2's heel admitted and then identified as d R2 has not had a treatment d she had just today, sent Doctor to see if they could ent order. At 1:40PM, E13 e sore was a full thickness skin own edges and had been like ek. manufacturer's information for by the facility on 9-15-11, nagement of healing wounds onal barrier to the delicate skin uring the healing process. o on 9-15-11 at 9:45AM, with d Specialist/Nurse for d the only time Sureprep is to ct intact skin. It should not be ess loss. It's contraindicated	F	314	4		

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 146059 09/16/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **873 GROVE STREET** HERITAGE HEALTH-JACKSONVILLE **JACKSONVILLE, IL 62650** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 Continued From page 10 F 314 poor intake with recommendation for supplement due to weight loss and open area. R2's TAR shows R2 weighed 118 lbs on 9-1-11 and 9-7-11 yet there in no Nutritional Assessment address the significant weight loss or the decline in pressure sore. The Facility was informed of concern on 9-14-11 and had the Dietitian assess on 9-15-11 with recommendation for increased nutritional supplement. R2's laboratory test of 9-7-11 show total protein and albumin are within normal limits. During interview with E19, LPN, on 9-15-11 at 3:45PM, E19 stated she does treatments to R2's heel. E19 stated when she first saw R2's left heel it was a blister. E19 states its now real beefy red with brown dried edges. She said she changes the dressing every night when she works. Last week the blister broke and they were still using skin prep (Sureprep) to the heel. The heel didn't seem to be improving over the weekend. E19 stated she felt the skin prep was not working and the pressure sore was getting worse. E19 felt the treatment needed to be changed and on Sunday, September 11, 2011, she let the night Nurse so the Physician could be notified. Nurses Notes of 9-14-11 at 2325 document R2's Physician was faxed update with regards to treatment to left heel - no improvement. Fax provided by E21, Corporate Nurse, showed Fax Communication form dated 9-15-11 at 0730 sent to R2's Physician documenting R2 "has current order for skin prep L heel. Area now open can we DC (discontinue) current order et change to cleanse dly (daily with normal saline or wound wash, apply silvasorb gel to open area Cover with foam pad et wrap with kerlix?" Fax was signed with OK and sent back to the facility on 9-15-11 at 1431.

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		AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		146059	B. WING _		09/16	6/2011
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HEALTH-JACKSO	NVILLE		873 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ige 11	F 314	L		
	8/29/11, R3 require transfers and bed n incontinent of bladd 8/31/11 identifies R pressure ulcer deve indicate Albumin is Total Protein 5.7 (N normal. The Regis weight gain of 5 por Physician's Order s 2011 indicates R3 r three times daily. T identifies R3 at risk The Pressure UI as developing an in right trochanter on a also reflect the press measured 1.6cm x the center measurin There is no justificat this ulcer and no ex was not identified p necrotic area. The 9/1/11 reflects the i trochanter and an a the same area which staged at a II which On 9/16/11 at 10 (DON) identified R3 pressure ulcers bei documentation, Clir sore guide tool", tha Hemiplegia and chr having labs that ind malnutrition and/or	nimum Data Set (MDS) dated es extensive assist of staff for nobility and is frequently der. The Braden Scale dated 3 as a "moderate risk" for elopment. Labs dated 4/13/11 2.6 (normal 2.4 - 4.3) and Jormal 5.1 - 7.2) are both stered Dietician identified a unds on 8/18/11. The sheet (POS) for September receives Med Pass 120cc The care plan dated 7/14/11 for skin breakdown. Icer weekly report identifies R3 n-house acquired ulcer on her 8/21/11. The nurses notes ssure sore and indicates it 1.4cm with a necrotic area in ng 0.5cm x 0.2cm, stage III. ation for the development of kplanation as to why the area prior to the development of the e "Weekly Ulcer Report" dated nitial ulcer on the right additional ulcer developing in ch measured 1.0cm x 0.2 n began as a blister. 0:30am, E2 Director of Nursing 3 as being on Hospice and the ing "unavoidable" offering nically unavoidable pressure at lists R3 as having ronic urinary incontinence and dicate R3 may be at risk for dehydration/poor healing. The neterventions implemented at				

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		AND HUMAN SERVICES					APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		146059	B. WI	NG _		09/16	6/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HEALTH-JACKSO	NVILLE			JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	the time the ulcer w any reference to he E15, Certified Nurs 12:45pm, that R3 h months and always side when in bed so R3 was observe and/or in the dining except for toileting. The ULCER POLIC all residents will be quarterly and as ch includes protocol for residents. Moderat checks are complet checks by CNA (Ce day using the "skin policy continues un that "residents with at high risk automa documentation that following the develop pressure ulcer. 3. The Facility Car 10/28/11 document include; Diabetes M Depressive Disorde generalized pain. R problem area of ski stage one pressure the area of goals is discontinued on 9/7 the current MDS da 14 requires extensi	vere identified but don't include er right side. Interview with es Aide, said on 9/16/11 at has declined in the past couple insists on laying on her right o she can face the wall. ed to sit in her chair at bedside room throughout the survey	F	314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		146059	B. WI	NG		09/1	6/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E HEALTH-JACKSO	NVILLE			73 GROVE STREET ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314 F 315 SS=D	for pressure ulcers relieving devices in of the Facility "Wee of 9/1/11 documen pressure ulcer to th 1.7 centimeters, an to the left heel mea Ulcer Report dated Right heel wound is measures 2.1 by 2. documentation of a area. A skin check dor on 9/14/11 at 4:30P has a darkened are non-blanching. E20 something there so until it is gone." Skin check with F 14 was observed to area applied to her was removed, the e and towards the cel with skin peeling ba stated, "well I asked this dressing becau (R14), and she stat that on because of No we have not bee area." 483.25(d) NO CATH RESTORE BLADD Based on the reside assessment, the fac	also assessed as being at risk and requires pressure bed and in the chair. Review kly Ulcer Report" for the week ts that R14 has a Stage one e right heel measuring 2.5 by d a stage two pressure ulcer suring 0.5 by 0.3. The Weekly 9/8/11 documents that R14's a resolved and the left heel 5 centimeters. There is no ny dressing to R 14's coccyx the with E20 Registered Nurse, M. Observed that Right heel a, firm to the touch, and stated, " there is still we should be tracking that E16 on 9/14 /11 at 4:00PM. R have an occlusive dressing coccyx. When the dressing entire coccyx was reddened inter were several open areas ick in small sections. E 16 d the wound care nurse about se we didn't have any for ed, hospice has been putting irritation due to incontinence. en tracking or measuring that HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a a the facility without an		314			10/16/11
SS=D	RESTORE BLADD Based on the reside assessment, the far resident who enters	ER ent's comprehensive cility must ensure that a					

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		146059	B. WI	NG .		09/1	6/2011
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE HEALTH-JACKSO	NVILLE			873 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 315 F 323 SS=G	resident's clinical or catheterization was who is incontinent of treatment and servi infections and to re function as possible This REQUIREMEN by: Based on observat facility failed to ens 2 residents, R2, rev sample of 26. Findings include: 1. Record revie Physician Order Shi indwelling urinary c order for Levaquin UTI. R2 was observe be incontinent of bo catheter. E22 and E23, CNA incontinent care bu catheter tubing. 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and	ondition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder e. NT is not met as evidenced tion and record review the ure good catheter care for 1 of viewed for catheter care in the w of R2's September neet documents R2 has a atheter. R2's POS shows an 250 mg daily on 9-7-11 for a ed on 9-14-11 at 10:10AM to owel and had a urinary 's were observed to do t failed to cleanse R2's E ACCIDENT		31	5		10/16/11

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		146059	B. WI	NG _		09/1	6/2011	
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
HERITAC	GE HEALTH-JACKSO	NVILLE	873 GROVE STREET JACKSONVILLE, IL 62650					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 323	Continued From pa	ige 15	F	323				
	by: Based on interview review, the facility f receive adequate s assistance to preve residents R7, R17, residents reviewed in the sample of 26 obtaining a left hip Findings include: 1. The Minimum Da documents R19 as memory deficits wit impairment and rec mobility. The Fall A identifies R19 at a Care Plan dated 04 needing assistance wheeled walker wit bathroom and walk The Occurrence Re AM, documented R floor in the resident documented cognit "no injuries noted." additional informati tear 3.5 x 2.5 x 0" a given as "I was rea today and there wa hit my arm then." T	ata Set (MDS) dated 04/13/11 having short/long term h moderate cognitive guires assist of one staff for ssessment dated 03/21/11 moderate risk for falls. The k/12/11 identifies R19 as of one with a gaitbelt and h transfers, ambulation to/from						

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		HAND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		146059	B. WIN	IG		09/10	6/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HEALTH-JACKSO	NVILLE		-	73 GROVE STREET ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	area for resident to within easy reach. A until resolved. Will room for any sharp skin tears." Another Occurrenc 7:31 PM, documen floor in dining room documented cognit "pain when ROM pe of left hip/leg pain, Documentation indi transported via am Hospital documenta sustained a Left Hip Notes indicated tha without assist of sta evening approachir 04/28/11, R19 was 04/28/11, the Care alarm" was added a On 09/13/11 at 10:3 Facility attributed th 04/22/11. On 05/03/11 at 11:3 documented that R resident's room, lay back." The report do measures at the tin cognitive level was The report docume Taken:Alarm app	put coffee and other items Will continue to monitor area have maintenance look at edges to help prevent future e Report dated 04/22/11 at ted R19 was "observed on i." The report further ive level of "oriented x 1" and erformed, resident complained outside services required." icated that R19 was bulance to the hospital. ation indicated that R19 p Femoral Neck Fracture and Hemiarthroplasty. Nurses at R19 was repeatedly walking aff and/or walker days and the ng the fall on 04/22/11. On readmitted to the Facility. On Plan indicated "personal	F3	323			

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146059	B. WI	NG _		09/1	6/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HEALTH-JACKSO	NVILLE			73 GROVE STREET IACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG			PREF	ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 323	On 05/12/11, the "E Assessment" docur extensive assist of wheeled walkerEx bed mobility, dressi also" On 08/20/11 at 12:3 documented that R his back with his he room." The prevent fall "Alarm: none." T resident statement think that I lost my b bad hip start hurting indicated that R19 to to the hospital for tr same day. On 08/2 pain of the left hip/le transferred to the he diagnoses of Anem 2. Per the admission current diagnoses w Vascular Accident, Senile Dementia, In Chronic Urinary Tra MDS dated 7/11/11 severely cognitively long term memory p Assessment dated is at high risk for fal Target date of 10/2 of Mobility deficits of connection to R17's or UTI symptoms th	inge 17 Endurance/Functional Ability mented R19 "transfers with 1-2 using gait belt and xtensive assist for toileting, ing and personal hygiene 30 AM, an Occurrence Report 19 was "observed on floor on ead near closet in resident's tion measures at the time of The report documented "I don't know for sure but I balance and fell. It made my g again." Documentation was transferred via ambulance reatment and returned later the 4/11, after many complaints of eg by R19, R19 was ospital and admitted with the ia and Urinary Tract Infection. Ons face sheet R17 has which include; Cerebral Transient Ischemic Attack, noomnia and Acute and act Infections. The most recent documents that R 17 is y impaired, with both short and problems. The Facility Fall 7/10/11 documents that R 17 Ils. The Plan of Care with the 5/11 under the problem area does not include any s Urinary Tract Infections (UTI) nat warrant interventions or the upervision for R17 during these	F	323			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146059 NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTH-JACKSONVILLE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		A. BUILD B. WING	BTREET ADDRESS, CITY, STATE, ZIP CODI 873 GROVE STREET JACKSONVILLE, IL 62650 PROVIDER'S PLAN OF CORF	CORRECTION (X5)		
TAG			TAG	CROSS-REFERENCED TO THE AI DEFICIENCY)		DATE
F 323	Facility Occurren 1/30/11, 3/8/11, 5/3 8/28/11 and 8/30/17 repeated falls. The dated 6/2/11 states while at the nurses intervention recomm states, "Current Brod drop seat wheelcha The 6/25/11 Occurr floor next to Broda witnesses, head tra changes in care inter the facility between The Facility occurren documents R17 fell at the bedside. Fac to, "continue curren re-evaluate effective 8/30/11 from her be fall per the report re changes in care inter between the 8/28 a Facility follow up notes that R 17 "ha and increased rest attempts to toilet he state, continue curr effective when (R17 Tract infection." The interventions/recom occurrence report of increased supervisi display signs/sympt Infection. E17, LPN, state 9/13/11 at 10:30 AM	nce reports dated 10/12/10, 11/11 6/2/11, 6/25/11, 7/15/11, 1 document that R17 had Facility Occurrence report , " Fell out of Broda Chair station, no witnesses." The mendation for this incident oda Chair to be replaced with air and self releasing seat belt." rence Report states, "fell on chair out in common area, no auma notedabrasion." No erventions were provided by the 6/2 fall and the 6/25 fall. ence report dated 8/28/11 I out of her bed on to the mat ility Recommendations were at safety measure and eness." R 17 fell again on ed to the mat on the floor. This esulted in a head injury. No erventions had been made nd 8/30/11 fall. o written by E3,RN, on 8-31-11, d an elevated temperature essness with frequent erself. Recommendations ent safety measure which are 7) does not have a Urinary	F 32	23		

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		HAND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		146059	B. WIN	IG		09/1	6/2011
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HEALTH-JACKSO	NVILLE			73 GROVE STREET ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 323	On 9/13/11 at 1 got the bruise as a she has these falls infection. She gets and crawls out of be On 9/13/11 at 1 her Broda chair in t R17's left side of he extending from her 3. R25 nurses note tear on 7/14/11 and fails to include fragi prevention plan ado R25's nurses no 11:53pm document CNA) reports repos resident up in bed or right upper arm to p tear" measuring 4ct The area was clear physician was notifit The report fails to the upper arm as he plan to prevent furth According to the 8/31/11. Pictures of 9/15/11 from Z4, fu have the skin tear of have an open skin the with his right great to on. This was confirm contained no inform and/or the left elbow E2, Director of Nu sheets showing tha wound but was una	1:30AM, E3 stated "yes she result of that fall, we know when she gets a urinary tract more restless and agitated, ed or out of her chair." 1:30am, R17 was observed in the dining room at the table. er face was black/blue/purple hairline to her upper neck. es indicate he sustained a skin d on 8/28/11. The Care plan ile skin/skin tears and a dressing this. otes written on 8/28/11 at ts that "(Certified Nurses Aide, sitioning in bed - pulling c (with) his assist - grabbed pull up in bed - received skin m x 2cm in half moon shape. nsed and steri-striped after the ied. to identify lifting a resident by armful and fails to include a her skin tears. e nurses notes, R25 expired on of R25's body received on ineral director, show him to on the upper right arm but also tear on his left elbow along toe which also had a skin tear med by Z4. The nurses notes nation on the right great toe w. ursing provided wound care at R25 had a left second toe	F 3	323			

CENTER		AND HUMAN SERVICES	(X2) MULTIPLE CONSTRUCTION			PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI			COMPLE	
		146059	B. WI	√G		09/10	6/2011
NAME OF P	ROVIDER OR SUPPLIER		_		REET ADDRESS, CITY, STATE, ZIP CODE	_	
HERITAG	GE HEALTH-JACKSO	NVILLE			373 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	have been steri stri additional skin tear undocumented. 4. R22's Occurrent 02:00, documented resident in sit to sta bathroom to use toi bump the frame of and caused skin tea right upper arms wa 1cm. In an interview of 1:45p.m., E3 stated checked for sharp e wider high back wh would mentor staff chair. Interview of I E15 stated R22 had chair, did not inserv chair and that E26, address transfers. at 2:01p.m., E26 sta inservice E28 on ta Inservice E28 on ta Interview of E26	ped or that he sustained an on his left elbow which went d "staff (E28, CNA)) had and was moving her into the ilet when her right upper arm doorway into the bathroom ar." It was also noted that her as bruised with a skin tear of f E3, RN, on 9-16-11 at d R22's door frame was edges, R22 was provided a ieel chair and E15 (CNA) concerning R22's new wheel E15, on 9-16-11 at 1:56p.m., d been provided a new wheel E15, on 9-16-11 at 1:56p.m., d been provided a new wheel Restorative LPN, would Interview of E26, on 9-16-11 ated E27, Restorative Aide, transfers. Interview of E27, on ., stated E28 went on light duty transfer and that she did not	F	323			
	had been assessed to stand transfer aff 5. R7's MD, dated cognitive impairmen one to two plus person mobility, transfer an	 5-9-11" when asked if R22 d for the appropriateness of sit ter the 6-4-11 incident. 7-24-11, documented sever nt and extensive assistance of sons physical assistance with ambulation. R7's Care 1-30-11, documented potential 					

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		AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		146059	B. WING		09/16	6/2011
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HEALTH-JACKSO	NVILLE		873 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	for injury related to physical limitation a It was also noted "o wheelchair". R7's (11-30-11, documer integrity. It was als work bilateral uppe arms of wheelchair R7's Occurrence to 8-18-11, documer skin tear on right ha "continue with (arm 2cm skin tear on le "continue with (arm hand skin tear with with (arm protectors released her "clip b discontinue her "clip bruise with interven protectors) on resid right wrist bruise wi sleeves or (arm pro R7 was observe with her wheel chai arm of her wheel chai	falls due to impaired cognition and lack of safety awareness. clip belt with an alarm while in Care Plan, target date ated potential for impaired skin o noted "(arm protectors) to be r extremities" and "padded for protection." e Reports, dated from 4-23-11 ented: 4-23-11, 1 cm xc 2cm and with an intervention to protectors)"; 5-2-11, 2cm x ft thumb with an intervention to protectors)"; 5-21-11, right an intervention to "continue s)"; 7-19-11, fall after R7 elt" with an intervention to p belt"; 7-21-11, right elbow tions to "place protective (arm lent's arms"; and, 8-18-11, th an interview to provide "long otectors).": ed, on 9-13-11 and 9-14-11, r "clip belt" in place, the right nair torn and pieces of torn al rubbing against her right arm e bilateral "(arm protectors)" or	F 323			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 146059 09/16/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **873 GROVE STREET** HERITAGE HEALTH-JACKSONVILLE **JACKSONVILLE, IL 62650** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 22 F 323 is at bedside and there is a sensor paid on her bed." It was also noted her alarm was not sounding at time of fall. R21's Occurrence reports, dated 3-19-11 to 8-15-11, documented: 3-19-11, at 17:00, R21 fell during unassisted toileting, 3-19-11, at 22:20, R21 was found lying on her back in the middle of the floor and her alarm was not sounding: 3-25-11, at 18:50, left knee abrasion from a fall during unassisted ambulation and her alarm was not sounding; 4-15-11, at 20:55, R21 bumped her head on a dining room chair during unassisted transfer, 6-20-11, at 20:25, R21's roommate informed staff at the nursing station that R21 had fallen after she attempted unassisted ambulation, 6-24-11, at 22:00, R21 fell after an attempted self transfer, 7-18-11, at 22:30, fell from bed and her alarm was not sounding; and, 8-25-11, at 22:10, R21 received a right and left knee abrasion after she was found laying on a mat by her bed. R21's Care Plan, target date 9-30-11, documented potential for injury related to falls due to impaired cognition, limited physical, mobility and lack of safety awareness. It was also noted personal alarm in chair while in room and motion sensor alarm for use while in bed. R21's Care Plan did not document R21's sundowning or interventions related evening activities and fall history ... R21's chart did not document an assessment of the effectiveness of the alarm to prevent falls. Interview of E8, on 9-16-11 at 10:00a.m., E8 stated when R21 would stand up her alarm would go off immediately and staff were not able to assist her in time. E8 did not provide an alarm assessment. 483.25(I) DRUG REGIMEN IS FREE FROM F 329 F 329 10/16/11 UNNECESSARY DRUGS SS=G

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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AID SERVICES			-	APPROVED 0938-0391
DER/SUPPLIER/CLIA FICATION NUMBER:	· ,		(X3) DATE SU COMPLE	JRVEY
146059	B. WING _		09/16	6/2011
DEFICIENCIES RECEDED BY FULL ING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
	F 329			
must be free from cessary drug is any dose (including essive duration; or or without adequate e presence of indicate the dose nued; or any above. ssessment of a ure that residents otic drugs are not psychotic drug a specific condition d in the clinical e antipsychotic eductions, and ss clinically o discontinue these met as evidenced ations and record equately monitor for g care; the ffects of the k to an overall ities and sidents reviewed for a sample of 26. owing a decline in				
	DEF/SUPPLIER/CLIA I146059 DEFICIENCIES RECEDED BY FULL NG INFORMATION) must be free from cessary drug is any dose (including essive duration; or or without adequate e presence of indicate the dose nued; or any above. ssessment of a ure that residents otic drugs are not psychotic drug a specific condition d in the clinical e antipsychotic eductions, and ss clinically o discontinue these met as evidenced ations and record equately monitor for g care; the ffects of the k to an overall ties and sidents reviewed for	DER/SUPPLIER/CLIA (X2) MULT A. BUILDIN 146059 Image: Strict Stri	DEFISUPPLIER/CLIA IGATION NUMBER: (X2) MULTIPLE CONSTRUCTION 146059 B. WING 146059 STREET ADDRESS, CITY, STATE, ZIP CODE 873 GROVE STREET JACKSONVILLE, IL 62650 DEFICIENCIES RECEDED BY FULL NG INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY) must be free from cessary drug is any dose (including ussive duration; or or without adequate e presence of indicate the dose nued; or any above. F 329 ssessment of a ure that residents bitic drugs are not psychotic ductions, and ss clinically discontinue these F 329 met as evidenced titions and record equately monitor for g care; the ffects of the k to an overall ties and sidents reviewed for a sample of 26. H	DERISUPPLIERCLIA TCATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SL COMPLE B. WING 146059 B. WING 09/11 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 873 GROVE STREET JACKSONVILLE, IL 62650 09/11 DEFICIENCIES RECEDED BY FULL No INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) must be free from cessary drug is any dose (including ussive duration; or or without adequate e presence of indicate the dose nued; or any above. F 329 sesessment of a ure that residents bitic drugs are not psychotic ductions, and es antipsychotic ductions, and es clinically d iscontinue these Image: Complexity of the complexity of the complexity of the complexity of the clinical equately monitor for g care; the ffects of the k to an overall ties and sidents reviewed for a sample of 26. Image: Complexity of the clinical end the clinical

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CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
			A. BUI		G		
		146059	B. WIN	IG		09/16	6/2011
NAME OF P	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE 73 GROVE STREET		
HERITAC	GE HEALTH-JACKSO	NVILLE			ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	condition as docum Set (MDS). Findings include: 1. According to the (POS) for Septemb Risperdal 1mg at bo ordered on 6/23/11 Behavioral Disturba Hallucinations." Th Section E BEHAVIC having no hallucina behavioral symptom notes from 4/26/11 only one behavior a R3 was documente she could "cut hers On 6/21/11, R3 v physician for the me "according to nursir has been fairly stab Psychiatrist is docu writes R3 "for an inv bizarre grandiose d increasingly agitate to the point of havir she claimed that sta Psychiatrist ordered increased her Celes Namenda 20mg an no justification for th clinical record inclu- shows no evidence related to staff care investigation, the ac time event in which	e Physician's Order Sheet ber 2011, R3 is receiving edtime (HS) which was 1 for "Dementia with ances" and "Psychotic with be Minimum Data Set (MDS) ORS (5/31/11) identifies R3 as titions or delusions and no ms being present. The nurses through 6/23/11 document as occurring on 4/28/11 when ed as asking for a scissors so	F 3	329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146059 NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTH-JACKSONVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(X2) M A. BUI B. WIN	LDING IG STR 87	REET ADDRESS, CITY, STATE, ZIP CODE 73 GROVE STREET ACKSONVILLE, IL 62650 PROVIDER'S PLAN OF CORREC	FORM. OMB NO. (X3) DATE SL COMPLE 09/10	TED 6/2011
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)		COMPLETION DATE
F 329	during incontinent of On 9/16/11 at 11 (RN) said R3 has h that including resist behaviors, and incre- in the addition of the incident of 6/23/11. yesterday (9/15/11) behavioral tracking behaviors and has a Tracking sheets da having resisting car accusations about p On 9/16/11 at 10 stated R3 had no be but did have some a admission which has stated she visited R aware that they had Alzheimers recently Risperdal was an a On 9/16/11 at 12 Practical Nurse (LP behaviors" but does behavioral tracking administration recon On 9/16/11 at 12 had an incident a co accused the staff be incidents. E15 said decline in the past of she used to talk all and no longer does at bedside in her wi E15 said R3 will residoesn't talk like she On 9/13/11 from	care at night. 1:45am, E3 Registered Nurse ad an increase in behaviors sing care, accusatory eased agitation which resulted e Risperdal following the E3 stated she realized that she did not have sheets out for the right since added those in. ted 9/16/11 identify R3 as re issues and making false people (staff and family). Dam, R3's family member (Z2) ehaviors that she was aware adjustments problems on ad been over a year ago. Z2 R3 often at the facility and was d started R3 on medication for / but did not know that the ntipsychotic medication. 2:40pm, E16, Licensed PN) said R3 "used to have sn't anymore and provided sheets from the medication rds and aides books. 2:45pm, R15 CNA stated R3 ouple months ago where she ut has not had any additional d "Actually, R3 has had a couple months" adding that the time and attend activities either. E15 stated she will sit heelchair with her eyes shut. spond when spoken to but	Εŝ	329			

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		146059	B. WI	NG _		09/1	6/2011
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HEALTH-JACKSO	NVILLE			873 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	meal after taking a intake being < 25% at 12:55pm with no did respond to the 0 9/15/11, from 9am noted to be sitting a with her eyes close attend and/or partic the survey process The MDS date behaviors for R3 bu from the MDS date to extensive assist an on staff. The Admission 3 be a 92 year old fer on 12/28/10 with dia Disease, Hemipleg depression. 2. R10's POS show mg of Risperdal. R behaviors. Record PSYCHOACTIVE M FLOW RECORDS 2011 show R10 rec delusions. Flow rea no delusions. During interview 3:45PM, E3 confirm delusions and state R10's Risperdal no In the morning of Nursing, provided a Communication to	ed the majority of her lunch couple bites by herself with . R3 was toileted on 9/13/11 resisting behaviors noted and CNA's when spoken to. On until 11:25am, R3 was again at bedside in her wheelchair d. R3 was not observed to sipate in any activities during d. 8/29/11 fails to identify any ut reflects a decline in eating d 5/31/11 as setup/supervision hygiene from minimal to d bathing to total dependency sheet for R3 identifies her to male readmitted to the facility agnoses of Cerebral Vascular ia, hypertension and ws an order of 2-28-11 for .5 10's MDS of 8-6-11 shows no review of R10's MEDICATION MONTHLY for June, July and August seives Risperidone .5 mg for cords show documentation of with E3, on 9-15-11 at hed R10 is not having ed they had just decreased	F	329			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 146059 09/16/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **873 GROVE STREET** HERITAGE HEALTH-JACKSONVILLE **JACKSONVILLE, IL 62650** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 329 Continued From page 27 F 329 with an order dated 9-16-11 from R10's Physician to lower the Risperdal to .25 mg. F 441 483.65 INFECTION CONTROL, PREVENT F 441 10/16/11 SS=D SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -(1) Investigates, controls, and prevents infections in the facility: (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		146059	B. WING		09/10	6/2011
NAME OF P	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE HEALTH-JACKSO	NVILLE		873 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 441	Continued From pa infection.	ıge 28	F 441	1		
	by: Based on observat facility failed to ensi- care for 2 of 12 res	NT is not met as evidenced tion and record review the ure good handwashing during sidents, R2 and R10, reviewed continent care, in the sample				
	Findings include:					
	Order Sheet docum urinary catheter. R Levaquin 250 mg d R2 was observe be incontinent of bo catheter. E22 and E23, Certi- observed to do inco observed to handle	of R2's September Physician nents R2 has a indwelling 2's POS shows an order for laily on 9-7-11 for a UTI. ed on 9-14-11 at 10:10AM to owel and had a urinary fied Nurse Aides (CNA's) were ontinent care. R23 was a R2's new incontinent brief e same soiled gloves she had continent care.				
	8-6-11 identifies R1 bladder. On 9-14-11 at 12 give incontinent car incontinent of urine feces. E25 had a b dry wash clothes. E peri wash and woul repeatedly without of	of R10's Minimum Data Set of 10 is incontinent of bowel and :45PM, E25 was observed to re to R10. R10 had been and a large amount of loose basin of water, peri wash and E25 wet a wash cloth, apply Id wipe feces from R10 changing her gloves. E25 was R10's clean blanket, bed frame				

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CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
			A. BUILDIN				
		146059	B. WING		09/1	6/2011	
NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTH-JACKSONVILLE			8	REET ADDRESS, CITY, STATE, ZIP CODE 73 GROVE STREET ACKSONVILLE, IL 62650			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 441		age 29 ring repositioning while	F 441				
F9999	wearing the same FINAL OBSERVAT	soiled gloves.	F9999				
	Licensure Violatio	ns:					
	300.610a) 300.1210d)5) 300.3240a)						
	a) The facility shall procedures, govern the facility which sl Resident Care Poli least the administra the medical adviso representatives of the facility. These p with the Act and all These written polic operating the facilit least annually by th written, signed and meeting	nursing and other services in policies shall be in compliance rules promulgated thereunder. ies shall be followed in ty and shall be reviewed at his committee, as evidenced by dated minutes of such a					
	Section 300.1210 (Nursing and Perso	General Requirements for nal Care					
	care shall include, and shall be practive seven-day-a-week 5) A regular progra pressure sores, he breakdown shall be	basis: Im to prevent and treat at rashes or other skin e practiced on a 24-hour, basis so that a resident who					

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If continuation sheet Page 30 of 54

CENTER		AND HUMAN SERVICES		<u> </u>	IPLE CONSTRUCTION	FORM	02/25/2012 APPROVED 0938-0391
		IDENTIFICATION NUMBER:	(X2) N A. BU			COMPLE	
		146059	B. WI	NG		09/10	6/2011
NAME OF P	ROVIDER OR SUPPLIER		_		REET ADDRESS, CITY, STATE, ZIP CODE	_	
HERITAGE HEALTH-JACKSONVILLE					373 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	develop pressure s clinical condition de sores were unavoid pressure sores sha services to promote and prevent new pr Section 300.3240 A a) An owner, licens agent of a facility sh resident. Based on observati review, the facility fa accurately assess, treatments for press for 3 of 5 residents for pressure sores i resulted in R2 havin size in her pressure non-blanchable are unstageable pressure in her pressure unstageable pressure with drainage. This developing an avoid right trochanter that and treat until it was Findings include: 1. Record review of 8-15-11 shows doc readmitted to the fa purple non-blancha Record review of Treatment Plan of pressure sore on R stage 1 "Non-blanc	iones unless the individual's emonstrates that the pressure dable. A resident having all receive treatment and e healing, prevent infection, ressure sores from developing. Abuse and Neglect see, administrator, employee or hall not abuse or neglect a ion, interview and record failed to consistently and monitor and implement new sure sores to prevent decline (R2, R3 and R14) reviewed in a sample of 26. This failure ng a decline and increase in e sore from purple ea on her heel to an ure sore with full thickness loss is failure resulted in R3 dable pressure sore on her t facility did not identify, assess	F9	9999			

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES				FORM OMB NO.	02/25/2012 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		146059	B. WI	IG		09/10	6/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGE HEALTH-JACKSONVILLE					73 GROVE STREET ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	intact. Size: length An undated note un documentation, "DT heel, waffles to feet brown, boggy et inta skin prep order." C (Treatment Nurse) note concerning DT Treatment Administ facility did not start order was obtained Allevyn heel dressin after a stage 1 was was assessed.) The next assessm Treatment Plan, sh 3.2 x 3.1 cm with <0 Serosanguinous dra note is written with tissue off, 100% red tunneling cont (com The next assess pressure sore is 3 > and no drainage an red dermis heel pro tx." The next assess documentation that <0.1 depth with sca ane 0.8 x 0.5 red de documents Physicia R2 was observed in bed and had an A	a, 3 width:2.5 Drainage: none" der Initial Entry Note: had I (deep tissue injury) to L (left t, et (and) floated, area dark act. Dr (Doctor) updated for on 9-16-11 at 11AM, E13 stated she had written the I on 8-18-11. (R2's tration Record (TAR) show the treatment until 8-22-11 when for skin prep and cover with ng and Kling. This was 7 days identified and 4 days after DTI ent of 8-25-11 on the ULCER - ows pressure sore measured 0.1 cm depth with scant ainage and is red in color. A documentation: "Necrotic d dermis, 0 undermining, 0 tinue) current TX" ment of 9-1-11 documents (3 cm with superficial depth id red in color. Note "100% otector in place cont current ment of 9-8-11 shows the pressure sore is 3.2 x 3 I black. Note states to	F99	9999			

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		I AND HUMAN SERVICES				-	APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	146059		B. WI	NG _		09/16/2011	
NAME OF PROVIDER OR SUPPLIER				STF	REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	GE HEALTH-JACKSO	NVILLE			73 GROVE STREET ACKSONVILLE, IL 62650		
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	U	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG		(MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Allevyn heel was st was dark brown dra was beefy red with areas. The beefy r wound. E14 cleans cleanser and gauze on the pillow at the opened a Sureprep over the pressure s until Sureprep dried in the same soiled dressing on R2's he using the same dre E14 confirmed she heel. E14 then stat took the dressing o gauze pad and con with brown drainag on the pillow and to touch her heel. E14 and when she cam foot and the pressur pillow. E14 put a n Allevyn heel, put the dressed with kling v pressure sore. On 9-15-11 at 10:2 was red when first a DTI. E13 confirme change. E13 state information to the E change the treatme stated the pressure loss with partial bro that for about a wea According to the	Ing from R2's heel. The uck to the wound and there ainage. The pressure sore edges that were black in some ed area was a full thickness sed the wound with wound e and then put R2's heel down foot of her bed. E14 then wipe and wiped around and ore. E14 fanned R2's heel d and then placed a gauze pad Allevyn heel and placed the eel. E14 was asked if she was ssing that she just took off and had used the same Allevyn ted maybe she shouldn't and ff R2's heel, took out the firmed the Allevyn was soiled e. E14 then placed R2's ankle ld her not to let the pillow 4 left the room to get supplies e back, R2 had rearranged her the sore was touching the ew gauze pad into a new e dressing on R2's heel and without re cleansing the 5AM, E13 stated R2's heel admitted and then identified as d R2 has not had a treatment d she had just today, sent Doctor to see if they could ent order. At 1:40PM, E13 e sore was a full thickness skin wn edges and had been like	F9	999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 146059 09/16/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **873 GROVE STREET** HERITAGE HEALTH-JACKSONVILLE **JACKSONVILLE, IL 62650** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 33 F9999 Sureprep is for management of healing wounds to provide an additional barrier to the delicate skin around a wound during the healing process. During an interview on 9-15-11 at 9:45AM, with Z3, Certified Wound Specialist/Nurse for Sureprep, Z3 stated the only time Sureprep is to be used is to protect intact skin. It should not be used on full thickness loss. It's contraindicated for full thickness loss wounds. Record review of Nurses Notes from 8-15-11 through 9-14-11 shows no documentation that R2's Physician was contacted of decline in the pressure sore. Physician order sheets from 8-22-11 through 9-14-11 show there was no change in treatment order even though the pressure sore on the left heel showed a decline. Nutrition Assessment of 8-24-11 shows R2 was admitted on 8-15-11 with a weight of 130 lbs and a DWR (desired weight range) of 97-138 lbs. The Assessment shows history of poor intake and estimated intake < 25%. Assessment documents general mechanical diet is adequate to meet nutritional needs, area on left heel DTI; poor intake with recommendation for supplement due to weight loss and open area. R2's TAR shows R2 weighed 118 lbs on 9-1-11 and 9-7-11 vet there in no Nutritional Assessment address the significant weight loss or the decline in pressure sore. The Facility was informed of concern on 9-14-11 and had the Dietitian assess on 9-15-11 with recommendation for increased nutritional supplement. R2's laboratory test of 9-7-11 show total protein and albumin are within normal limits. During interview with E19, LPN, on 9-15-11 at 3:45PM, E19 stated she does treatments to R2's heel. E19 stated when she first saw R2's left heel it was a blister. E19 states its now real beefy red

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	146059		B. WING	G		09/16/2011	
NAME OF F	ROVIDER OR SUPPLIER		;		EET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGE HEALTH-JACKSONVILLE					3 GROVE STREET ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	the dressing every week the blister bro skin prep (Sureprep seem to be improvi stated she felt the s the pressure sore w treatment needed to September 11, 201 the Physician could Nurses Notes of 9- Physician was faxe treatment to left here provided by E21, C Communication for to R2's Physician d order for skin prep we DC (discontinue cleanse dly (daily w wash, apply silvaso with foam pad et wa signed with OK and 9-15-11 at 1431. 2. According to Min 8/29/11, R3 require transfers and bed m incontinent of blado 8/31/11 identifies R pressure ulcer deve indicate Albumin is Total Protein 5.7 (N normal. The Regis weight gain of 5 po Physician's Order s 2011 indicates R3 r three times daily. T	Iges. She said she changes night when she works. Last oke and they were still using b) to the heel. The heel didn't ng over the weekend. E19 skin prep was not working and vas getting worse. E19 felt the b be changed and on Sunday, 1, she let the night Nurse so	F99	99			

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CENTEF STATEMENT AND PLAN O NAME OF P	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER GE HEALTH-JACKSO SUMMARY STA (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	A. BUIL B. WIN B. WIN	DING G STRE 87 JA	EET ADDRESS, CITY, STATE, ZIP CODE 73 GROVE STREET ACKSONVILLE, IL 62650 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	FORM OMB NO. (X3) DATE SU COMPLE 09/10	TED 6/2011 (X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	^	CROSS-REFERENCED TO THE APPR		DATE
F9999	The Pressure UI as developing an in right trochanter on a also reflect the press measured 1.6cm x the center measurin There is no justifica this ulcer and no ex was not identified p necrotic area. The 9/1/11 reflects the in trochanter and an a the same area whice staged at a II which On 9/16/11 at 10 (DON) identified R3 pressure ulcers bein documentation, Clin sore guide tool", that Hemiplegia and chr having labs that ind malnutrition and/or tool also includes in the time the ulcer w any reference to he E15, Certified Nurse 12:45pm, that R3 h months and always side when in bed so R3 was observe and/or in the dining except for toileting. The ULCER POLIC all residents will be quarterly and as cha- includes protocol for	Icer weekly report identifies R3 h-house acquired ulcer on her 8/21/11. The nurses notes ssure sore and indicates it 1.4cm with a necrotic area in ng 0.5cm x 0.2cm, stage III. ation for the development of kplanation as to why the area prior to the development of the e "Weekly Ulcer Report" dated nitial ulcer on the right additional ulcer developing in ch measured 1.0cm x 0.2 h began as a blister. 0:30am, E2 Director of Nursing 8 as being on Hospice and the ng "unavoidable" offering nically unavoidable pressure at lists R3 as having ronic urinary incontinence and licate R3 may be at risk for dehydration/poor healing. The neterventions implemented at vere identified but don't include er right side. Interview with es Aide, said on 9/16/11 at as declined in the past couple a insists on laying on her right o she can face the wall. ed to sit in her chair at bedside room throughout the survey	F99	99	DEFICIENCY)		

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		146059	B. WI	NG_		09/1	6/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HEALTH-JACKSO	NVILLE			373 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	checks are complete checks by CNA (Ce day using the "skin policy continues un that "residents with at high risk automa documentation that following the develop pressure ulcer. 3. The Facility Can 10/28/11 document include; Diabetes M Depressive Disorder generalized pain. R problem area of ski stage one pressure stage two pressure the area of goals is discontinued on 9/7 the current MDS da 14 requires extensi of daily living, is nor wheelchair. She is a for pressure ulcers relieving devices in of the Facility "Wee of 9/1/11 documen pressure ulcer to th 1.7 centimeters, an to the left heel mea Ulcer Report dated Right heel wound is measures 2.1 by 2. documentation of a area.	age 36 ted, as well as weekly skin ertified Nurses Aide) on bath observation worksheet." The der HIGH RISK to document existing ulcers will be scored tically." There is no R3 was reassessed for risk opment of the stage III re Plan with the target date of ts that R14 has diagnoses that delitis, Hypertension, er, Senile Dementia and eview of the care plan in, dated 8/30/11 documents a e ulcer to the right heel and area to the left heel. Under documented "right heel 7/11 and 9/8/11." Review of ated 7/14/11 documents that R ve assistance with all activities n- ambulatory and uses a also assessed as being at risk and requires pressure bed and in the chair. Review ekly Ulcer Report" for the week tts that R14 has a Stage one ne right heel measuring 2.5 by d a stage two pressure ulcer suring 0.5 by 0.3. The Weekly 9/8/11 documents that R14's a resolved and the left heel 5 centimeters. There is no any dressing to R 14's coccyx ne with E20 Registered Nurse,	F9	999			

		HAND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391	
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		146059	B. WI	NG				
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
HERITAG	GE HEALTH-JACKSO	NVILLE			73 GROVE STREET IACKSONVILLE, IL 62650			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F9999	on 9/14/11 at 4:30F has a darkened are non-blanching. E20 something there so until it is gone." Skin check with I 14 was observed to area applied to her was removed, the e and towards the ce with skin peeling ba stated, "well I asked this dressing becau (R14), and she stat that on because of No we have not bee area." 300.610a) 300.610c)2) 300.1210b)5) 300.1210b)5) 300.1210c) 300.1210d)2)6) Section 300.610 Re a) The facility shall procedures, govern the facility which sh Resident Care Polid least the administra the medical advisor representatives of r the facility. These p	PM. Observed that Right heel ea, firm to the touch, and o stated, " there is still o we should be tracking that E16 on 9/14 /11 at 4:00PM. R o have an occlusive dressing coccyx. When the dressing entire coccyx was reddened inter were several open areas ack in small sections. E 16 d the wound care nurse about use we didn't have any for ted, hospice has been putting irritation due to incontinence. en tracking or measuring that (B) (B) esident Care Policies have written policies and hing all services provided by hall be formulated by a cy Committee consisting of at ator, the advisory physician or	F9	9999				

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CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		146059	B. WI	NG _		09/16	6/2011
	ROVIDER OR SUPPLIER	NVILLE		8	REET ADDRESS, CITY, STATE, ZIP CODE		
		TEMENT OF DEFICIENCIES	ID	J	ACKSONVILLE, IL 62650 PROVIDER'S PLAN OF CORREC	τιονι	(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	These written polici operating the facility least annually by th written, signed and meeting c) These written po minimum the follow 2) Resident care set services, emergend nursing services, re- services, pharmace services, pharmace services, social ser services, and diagn laboratory and x-ray Section 300.1210 C Nursing and Persor a) Comprehensive with the participatio resident's guardian applicable, must de comprehensive car includes measurabl meet the resident's and psychosocial n resident's compreh- allow the resident to practicable level of provide for discharg restrictive setting ba needs. The assess the active participat resident's guardian applicable. b) The facility shall and services to atta	es shall be followed in y and shall be reviewed at is committee, as evidenced by dated minutes of such a licies shall include, at a ing provisions: ervices including physician ey services, personal care and estorative services, activity eutical services, dietary vices, clinical records, dental ostic service (including y).	F9	999			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 146059 09/16/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **873 GROVE STREET** HERITAGE HEALTH-JACKSONVILLE **JACKSONVILLE, IL 62650** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 39 F9999 well-being of the resident, in accordance with each resident's comprehensive resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures: 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 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. Based on interviews, observations and record review, the facility failed to ensure residents receive adequate supervision and proper assistance to prevent falls and skin tears for 6 residents R7, R17, R19, R21, R22 and R25 of 15 residents reviewed for falls and bruises/abrasions in the sample of 26. The failure resulted in R19 obtaining a left hip fracture.

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		146059	B. WI	NG _		09/1	6/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 373 GROVE STREET		
HERITAC	GE HEALTH-JACKSO	NVILLE			JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 40	F9	999			
	Findings include:						
	documents R19 as memory deficits wit impairment and rec mobility. The Fall A identifies R19 at a r Care Plan dated 04 needing assistance	ata Set (MDS) dated 04/13/11 having short/long term th moderate cognitive quires assist of one staff for ssessment dated 03/21/11 moderate risk for falls. The k/12/11 identifies R19 as of one with a gaitbelt and h transfers, ambulation to/from ing in corridor.					
	AM, documented R floor in the resident documented cognit "no injuries noted." additional informatii tear 3.5 x 2.5 x 0" a given as "I was rea- today and there wa hit my arm then." T "Steri strips applied on the report as "W area for resident to within easy reach. A until resolved. Will I room for any sharp skin tears." Another Occurrence 7:31 PM, document floor in dining room documented cognit "pain when ROM po	eport dated 04/10/11 at 8:55 19 was "observed sitting on 's room." The report further ive level of "oriented x 2" and On 04/10/11 at 8:00 PM, on was documented as "skin and a resident statement was ching for my coffee cup earlier s stuff in the way and I must of reatment documented as I." Interventions documented 'ill look at room to arrange put coffee and other items Will continue to monitor area have maintenance look at edges to help prevent future e Report dated 04/22/11 at ted R19 was "observed on ." The report further ive level of "oriented x 1" and erformed, resident complained outside services required."					

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		AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		146059	B. WING _		09/1	6/2011
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	GE HEALTH-JACKSO	NVILLE		873 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Documentation indi transported via amb Hospital documenta sustained a Left Hip underwent Left Hip Notes indicated tha without assist of sta evening approachin 04/28/11, R19 was 04/28/11, the Care alarm" was added a On 09/13/11 at 10:3 Facility attributed th 04/22/11. On 05/03/11 at 11:5 documented that R resident's room, lay back." The report d measures at the tim cognitive level was The report docume Taken:Alarm app changes made to th On 05/12/11, the "E Assessment" docur extensive assist of wheeled walkerE: bed mobility, dressi also" On 08/20/11 at 12:3 documented that R his back with his he room." The prevent	icated that R19 was bulance to the hospital. ation indicated that R19 p Femoral Neck Fracture and Hemiarthroplasty. Nurses at R19 was repeatedly walking aff and/or walker days and the ng the fall on 04/22/11. On readmitted to the Facility. On Plan indicated "personal	F9999			

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		146059	B. WI	NG		09/1	6/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HEALTH-JACKSO	NVILLE		_	73 GROVE STREET ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	think that I lost my I bad hip start hurting indicated that R19 y to the hospital for tr same day. On 08/2 pain of the left hip/lit transferred to the h diagnoses of Anem 2. Per the admission current diagnoses of Vascular Accident, Senile Dementia, Ir Chronic Urinary Tra MDS dated 7/11/11 severely cognitively long term memory Assessment dated is at high risk for fa Target date of 10/2 of Mobility deficits of connection to R17's or UTI symptoms th need to increase su times. Facility Occurrent 1/30/11, 3/8/11, 5/3 8/28/11 and 8/30/1 repeated falls. The dated 6/2/11 states while at the nurses intervention recomm states, "Current Bro drop seat wheelcha The 6/25/11 Occurrent floor next to Broda	ge 42 "I don't know for sure but I balance and fell. It made my g again." Documentation was transferred via ambulance reatment and returned later the 4/11, after many complaints of eg by R19, R19 was ospital and admitted with the ia and Urinary Tract Infection. Ons face sheet R17 has which include; Cerebral Transient Ischemic Attack, asomnia and Acute and act Infections. The most recent documents that R 17 is rimpaired, with both short and problems. The Facility Fall 7/10/11 documents that R 17 Ils. The Plan of Care with the 5/11 under the problem area does not include any s Urinary Tract Infections (UTI) hat warrant interventions or the upervision for R17 during these nce reports dated 10/12/10, 1/11 6/2/11, 6/25/11, 7/15/11, 1 document that R17 had Facility Occurrence report , " Fell out of Broda Chair station, no witnesses." The mendation for this incident oda Chair to be replaced with air and self releasing seat belt." rence Report states, "fell on chair out in common area, no auma notedabrasion." No	F9	999			

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		HAND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		146059	B. WI	NG		09/1	6/2011
NAME OF F	PROVIDER OR SUPPLIER	•			REET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HEALTH-JACKSO	NVILLE			73 GROVE STREET ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	changes in care int the facility between The Facility occurre documents R17 fel at the bedside. Fac to, "continue currer re-evaluate effectiv 8/30/11 from her be fall per the report re changes in care int between the 8/28 a Facility follow up notes that R 17 "ha and increased rest! attempts to toilet he state, continue curr effective when (R1 Tract infection." Th interventions/recorr occurrence report of increased supervisi display signs/symp Infection. E17, LPN, state 9/13/11 at 10:30 AN of R17's most recorr On 9/13/11 at 10 got the bruise as a she has these falls infection. She gets and crawls out of b On 9/13/11 at 10 her Broda chair in t R17's left side of he extending from her 3. R25 nurses note	terventions were provided by the 6/2 fall and the 6/25 fall. ence report dated 8/28/11 I out of her bed on to the mat cility Recommendations were not safety measure and veness." R 17 fell again on ed to the mat on the floor. This esulted in a head injury. No terventions had been made and 8/30/11 fall. to written by E3,RN, on 8-31-11, and an elevated temperature lessness with frequent erself. Recommendations rent safety measure which are 7) does not have a Urinary	F9	999			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 146059 09/16/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **873 GROVE STREET** HERITAGE HEALTH-JACKSONVILLE **JACKSONVILLE, IL 62650** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 44 F9999 fails to include fragile skin/skin tears and a prevention plan addressing this. R25's nurses notes written on 8/28/11 at 11:53pm documents that "(Certified Nurses Aide, CNA) reports repositioning in bed - pulling resident up in bed c (with) his assist - grabbed right upper arm to pull up in bed - received skin tear" measuring 4cm x 2cm in half moon shape. The area was cleansed and steri-striped after the physician was notified. The report fails to identify lifting a resident by the upper arm as harmful and fails to include a plan to prevent further skin tears. According to the nurses notes, R25 expired on 8/31/11. Pictures of R25's body received on 9/15/11 from Z4, funeral director, show him to have the skin tear on the upper right arm but also have an open skin tear on his left elbow along with his right great toe which also had a skin tear on. This was confirmed by Z4. The nurses notes contained no information on the right great toe and/or the left elbow. E2, Director of Nursing provided wound care sheets showing that R25 had a left second toe wound but was unable to provide any documentation as to why his right great toe would have been steri striped or that he sustained an additional skin tear on his left elbow which went undocumented. 4. R22's Occurrence Report, dated 6-4-11 at 02:00, documented "staff (E28, CNA)) had resident in sit to stand was moving her into the bathroom to use toilet when her right upper arm bump the frame of doorway into the bathroom and caused skin tear." It was also noted that her right upper arms was bruised with a skin tear of 1cm.

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CENTER STATEMENT		AND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146059	(X2) M A. BU B. WII	ILDIN	IPLE CONSTRUCTION	FORM OMB NO. (X3) DATE SU COMPLE	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE HEALTH-JACKSO	NVILLE		-	373 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	In an interview of 1:45p.m., E3 stated checked for sharp e wider high back why would mentor staff chair. Interview of I E15 stated R22 had chair, did not inservich chair and that E26, address transfers. at 2:01p.m., E26 sta inserviced E28 on t 9-16-11 at 2:06p.m. after R22's 6-4-11 t inservice E28 on tra- Interview of E26 stated R22's "last a stand transfer was had been assessed to stand transfer aff 5. R7's MD, dated cognitive impairmen one to two plus person mobility, transfer an Plan, target date 11 for injury related to physical limitation a It was also noted "c wheelchair". R7's C 11-30-11, document integrity. It was also work bilateral upper arms of wheelchair R7's Occurrence to 8-18-11, document skin tear on right has	f E3, RN, on 9-16-11 at d R22's door frame was edges, R22 was provided a eel chair and E15 (CNA) concerning R22's new wheel E15, on 9-16-11 at 1:56p.m., d been provided a new wheel rice concerning the new wheel Restorative LPN, would Interview of E26, on 9-16-11 ated E27, Restorative Aide, ransfers. Interview of E27, on ., stated E28 went on light duty ransfer and that she did not ansferring. 6, on 9-16-11 at 2:01p.m., E26 assessment of R22's sit to 5-9-11" when asked if R22 d for the appropriateness of sit ter the 6-4-11 incident. 7-24-11, documented sever nt and extensive assistance of sons physical assistance with nd ambulation. R7's Care I-30-11, documented potential falls due to impaired cognition and lack of safety awareness. slip belt with an alarm while in Care Plan, target date nted potential for impaired skin o noted "(arm protectors) to be r extremities" and "padded	F9	999			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 146059 09/16/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **873 GROVE STREET** HERITAGE HEALTH-JACKSONVILLE **JACKSONVILLE, IL 62650** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 46 F9999 2cm skin tear on left thumb with an intervention to "continue with (arm protectors) "; 5-21-11, right hand skin tear with an intervention to "continue with (arm protectors)"; 7-19-11, fall after R7 released her "clip belt" with an intervention to discontinue her "clip belt"; 7-21-11, right elbow bruise with interventions to "place protective (arm protectors) on resident's arms"; and, 8-18-11, right wrist bruise with an interview to provide "long sleeves or (arm protectors).": R7 was observed, on 9-13-11 and 9-14-11, with her wheel chair "clip belt" in place, the right arm of her wheel chair torn and pieces of torn plastic type material rubbing against her right arm and R7 did not have bilateral "(arm protectors)" or consistently wear long sleeves. 6. R21's MDS. dated 8-17-11. documented an diagnosis, in part, of Alzheimer's and extensive to total dependence of one to two person persons physical assistance with mobility, transfer and ambulation. R21's Occurrence Report, dated 3-19-11 at 15:40, documented "R21 sundowns in evenings and wants to pack up and go home." Per her statement she was looking for her suitcase under her bed and fell. An alarmed mat is at bedside and there is a sensor paid on her bed." It was also noted her alarm was not sounding at time of fall. R21's Occurrence reports, dated 3-19-11 to 8-15-11, documented: 3-19-11, at 17:00, R21 fell during unassisted toileting, 3-19-11, at 22:20, R21 was found lying on her back in the middle of the floor and her alarm was not sounding; 3-25-11, at 18:50, left knee abrasion from a fall during unassisted ambulation and her alarm was not sounding; 4-15-11, at 20:55, R21 bumped her head on a dining room chair during unassisted

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		HAND HUMAN SERVICES			FORM	: 02/25/2012 APPROVED . 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		146059	B. WING	IG	09/1	6/2011
NAME OF F	PROVIDER OR SUPPLIER		ç	STREET ADDRESS, CITY, STATE, ZIP COD	Ē	
HERITA	GE HEALTH-JACKSO	NVILLE		873 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE
F9999	transfer, 6-20-11, a informed staff at the fallen after she atte 6-24-11, at 22:00, F transfer, 7-18-11, a alarm was not sour R21 received a righ she was found layin R21's Care Plan documented potent due to impaired cog mobility and lack of also noted persona and motion sensor R21's Care Plan did sundowning or inter activities and fall his R21's chart did n of the effectiveness Interview of E8, stated when R21 w go off immediately assist her in time. assessment. 300.686a) 300.686d) 300.1210b)4)5) 300.1210d)3) 300.3240a)	t 20:25, R21's roommate e nursing station that R21 had empted unassisted ambulation, R21 fell after an attempted self at 22:30, fell from bed and her hding; and, 8-25-11, at 22:10, ht and left knee abrasion after ng on a mat by her bed. h, target date 9-30-11, tial for injury related to falls gnition, limited physical, f safety awareness. It was al alarm in chair while in room alarm for use while in bed. d not document R21's rventions related evening	F999			

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		HAND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		146059	B. WI	NG		09/1	6/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	GE HEALTH-JACKSO	NVILLE		-	73 GROVE STREET ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa Antipsychotic Drugs	s	F9	999			
	drugs in accordanc F. In addition, an ur used: 1) in an excessive of therapy; 2) for excessive du 3) without adequate 4) without adequate 5) in the presence of indicate the drugs s discontinued. (Sect c) Residents shall r drugs unless antips necessary, as docu comprehensive ass suspected condition documented in the the possibility of on accordance with Se d) Residents who u receive gradual dos interventions, unles an effort to disconti accordance with Se	e monitoring; e indications for its use; or of adverse consequences that should be reduced or tion 2-106.1(a) of the Act) not be given antipsychotic sychotic drug therapy is umented in the resident's sessment, to treat a specific or n as diagnosed and clinical record or to rule out e of the conditions in ection 300.Appendix F. ise antipsychotic drugs shall se reductions and behavior as clinically contraindicated, in inue these drugs in ection 300.Appendix F.					
	b) The facility shall and services to atta practicable physica well-being of the re- each resident's con plan. Adequate and	provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with nprehensive resident care d properly supervised nursing care shall be provided to each					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		146059	B. WI	NG		09/16	6/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE HEALTH-JACKSO	NVILLE			73 GROVE STREET ACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	resident to meet the care needs of the re- shall include, at a m procedures: 4) All nursing perso- encourage resident in activities of daily circumstances of th demonstrate that di This includes the re- dress, and groom; t eat; and use speech functional communi- who is unable to ca- shall receive the se good nutrition, groo 5) All nursing perso- encourage resident transfer activities as effort to help them m practicable level of d) Pursuant to subs care shall include, a and shall be practic seven-day-a-week f 3) Objective observ- resident's condition emotional changes, determining care re- further medical eva made by nursing sta- resident's medical r Section 300.3240 A a) An owner, license	e total nursing and personal esident. Restorative measures inimum, the following nnel shall assist and s so that a resident's abilities living do not diminish unless ie individual's clinical condition minution was unavoidable. esident's abilities to bathe, transfer and ambulate; toilet; h, language, or other ication systems. A resident rry out activities of daily living rvices necessary to maintain ming, and personal hygiene. nnel shall assist and s with ambulation and safe s often as necessary in an retain or maintain their highest functioning. ecction (a), general nursing at a minimum, the following ed on a 24-hour, basis: ations of changes in a , including mentaland as a means for analyzing and quired and the need for luation and treatment shall be aff and recorded in the ecord.	F9	999			

		AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE	JLTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		146059	B. WING	G	09/1	6/2011
NAME OF P	PROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE HEALTH-JACKSO	NVILLE		873 GROVE STREET JACKSONVILLE, IL 62650		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ıge 50	F999	99		
	review, the facility fa accusatory behavior effectiveness incluor Risperdal and the p decline including ea hygeine/bathing for Antipsychotic medior This failure resulted	s, observations and record vailed to adequately monitor for ors; resisting care; the ding side effects of the bossible link to an overall ating, activities and • 2 of 15 residents reviewed for dations in a sample of 26. d in R3 showing a decline in hented on her Minimum Data				
	Findings include:					
	(POS) for Septemb Risperdal 1mg at b ordered on 6/23/11 Behavioral Disturba Hallucinations." Th Section E BEHAVIC having no hallucina behavioral symptom notes from 4/26/11 only one behavior a R3 was documente she could "cut hers On 6/21/11, R3 v physician for the me "according to nursir has been fairly stab Psychiatrist is docu writes R3 "for an im- bizarre grandiose d increasingly agitate	e Physician's Order Sheet ber 2011, R3 is receiving edtime (HS) which was 1 for "Dementia with ances" and "Psychotic with he Minimum Data Set (MDS) ORS (5/31/11) identifies R3 as titons or delusions and no ns being present. The nurses through 6/23/11 document as occurring on 4/28/11 when ed as asking for a scissors so self loose." was seen by her primary onthly visit and documents ng staff, the patient apparently ole." On 6/23/11, the umented as seeing her and creasing paranoid persecutory lelusional system, becoming ed and accusatory of male staff ng a police investigation when				

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146059	B. WI	NG		09/10	6/2011
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGE HEALTH-JACKSONVILLE			873 GROVE STREET JACKSONVILLE, IL 62650				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 51 she claimed that staff had raped her." The Psychiatrist ordered Risperdal 1mg daily and increased her Celexa to 40mg daily and added Namenda 20mg and Aricept 10mg daily. There is no justification for the use of the Risperdal as the clinical record including behavioral tracking shows no evidence of continuing behaviors related to staff care. According to the facility's investigation, the accusation appeared as a one time event in which the facility determined to be R3 misunderstanding and confusion with staff during incontinent care at night. On 9/16/11 at 11:45am, E3 Registered Nurse (RN) said R3 has had an increase in behaviors that including resisting care, accusatory behaviors, and increased agitation which resulted in the addition of the Risperdal following the incident of 6/23/11. E3 stated she realized yesterday (9/15/11) that she did not have behaviors and has since added those in. Tracking sheets dated 9/16/11 identify R3 as having resisting care issues and making false accusations about people (staff and family). On 9/16/11 at 10am, R3's family member (Z2) stated R3 had no behaviors that she was aware but did have some adjustments problems on admission which had been over a year ago. Z2 stated she visited R3 often at the facility and was aware that they had started R3 on medication for Alzheimers recently but did not know that the Risperdal was an antipsychotic medication. On 9/16/11 at 12:40pm, E16, Licensed Practical Nurse (LPN) said R3 "used to have behaviors" but doesn't anymore and provided behaviors" but doesn't anymore and provided		F9	999			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146059	B. WINC	3		09/16	6/2011
NAME OF F	PROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY			
HERITAGE HEALTH-JACKSONVILLE				873 GROVE STREET JACKSONVILLE, II			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORREC RECTIVE ACTION SHOU ENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F999	99			

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		AND HUMAN SERVICES					APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	146059		B. WI	B. WING			09/16/2011	
NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTH-JACKSONVILLE					TREET ADDRESS, CITY, STATE, ZIP CODE 873 GROVE STREET JACKSONVILLE, IL 62650			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F9999	delusions. Flow re- no delusions. During interview 3:45PM, E3 confirm delusions and state R10's Risperdal no In the morning or Nursing, provided a Communication to with recommendati with an order dated	with E3, on 9-15-11 at ned R10 is not having d they had just decreased	F9	999	9			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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