PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		440055	B. WII			С	
		14G255				08/3	1/2011
	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH MAIN STREET HOYLETON, IL 62803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 000	INITIAL COMMEN	тѕ	W	000			
	INCIDENT INVEST	TIGATION					
W 111	Incident of 05/07/12 483.410(c)(1) CLIE		W	111	1		
	recordkeeping syst	evelop and maintain a em that documents the client's treatment, social information, ne client's rights.					
	Based on record r failed to ensure nur identified specific ir interventions in the	s not met as evidenced by: review and interview the facility rsing has evaluated and interventions and documented Individual Service Plan as the inged for 1 of 3 individuals					
	Findings Include:						
	identifies R1 as a 7 functions at the sev Retardation with ad Syndrome, Alzheim Hypercholesterolen Anemia, Gastroeso Chronic Obstructive Procedure Pacema of Gastric Resectio	(POS) of 7/1/11- 7/31/11 4 year old individual who vere range of Mental Iditional diagnoses of Downs her's, Hypothyroidism, hia, Esophageal Dyskinsia, hophageal Reflux Disease, e Pulmonary Disease, Surgical laker Insertion and Past History hin. ent titled, "Hospitalizations- lated) given to surveyor by E3/					
	Licensed Practical	Nurse on 8/10/11 at 2:15 PM, hospitalized as follows:					
LABORATOR	I Y DIRECTOR'S OR PROVID	 DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN		С	
		14G255	B. WING _		08/3	1/2011
	ROVIDER OR SUPPLIER		6	REET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET IOYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 111	Pneumonia	charged 4/15/11 Diagnosis: charged 5/16/11 Diagnosis: charged 6/13/11 Diagnosis:	W 111			
	Pneumonia / Sepis Admit 7/19/11 Disc	harged 7/7/11 Diagnosis: charged 7/22/11 Diagnosis: ion/ Electrolyte Imbalance				
	Admit 8/2/11 (no di hospitalized as of 8. Abnormalities	ischarge date/ remains /17/11) Respiratory				
	R1's Individual Servistates the following "Recommendations"					
	" Monitor for cardiac and report to nurse.	c and respiratory symptoms."				
		TI (urinary tract infection), ms of urinary tract infection."				
	specifically identify monitor. The recomidentify what type of urinary tract infection the Direct Support Fand report to nursing	of 10/6/10 does not what direct care staff are to mendations do not specifically f cardiac, respiratory, and on signs and symptoms that Professional are to monitor ag.				
	Consultation i offit	WITH ZZ/MUISE I TACITIONE				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING			С	
		14G255	B. WII	NG		08/31/2011	
	ROVIDER OR SUPPLIER			62	EET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET OYLETON, IL 62803		
(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
W 111	"Encourage fluids fi urine output or conf Review of Individua 7/12/11) states, "Ju change in her healt several times in the starting to be more hospitalized for asp further states, "Her consistency to ensu She is also to have convenience. She cand at times will no assist in feeding he Her intake has been encourage her to ear Review of the ISP recommendations of related to the consultations for R1 related to the consultations (4/11). Discharge Summar (4/15/11-7/22/11) the made by the Regist recommendations of to R1's change in made in the recommendations of the R1's change in made in the recommendations of the R1's change in made in the recommendations of the R1's change in made in the recommendations of the R1's change in made in the recommendations of the R1's change in made in the recommendations of the R1's change in made in the recommendations of the R1's change in made in the R1's change in mad	der recommendations states, requently, report decreased inued poor fluid intake." al Service Plan/ ISP (dated st recently R1 has had a h. She has been hospitalized last six months and it's frequent. She is usually iration pneumonia." The ISP liquids must be of honey are that she does not aspirate. her food pureed for her does require prompting to eat the feed herself. Staff do have to rewhen she is noncompliant. In poor and staff are to at." of 7/12/11 does not state any made by the RN of specific 's change in medical status altation of 5/24/11 or the medical status altation of 5/24/11 and Hospital by Instructions here is no documentation dered Nurse of any further of interventions made related	W	1111			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G	С	
		14G255	B. WING _			1/2011
NAME OF P	ROVIDER OR SUPPLIER		6	REET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET IOYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 111	interventions, E2 s assessments, she'll annual and will revistated that the RN vindividuals and that R1 on 7/12/11. E2 of 2011, the facility did staffing meetings ex R1's medical status other evidence of ZR1's ISP related to change in medical swas unable to proviwritten documentatis Support Profession changes in R1's menotifying RN consul 483.440(c)(4) INDIVITHE individual progrobjectives necessal as identified by the required by paragratical to identify specially individual (R1) in the recommendations of Findings Include:	ecommendations of tated "The RN does yearly I come in the month before the ew R1's record." E2 further will attend special staffing's for they had a special staffing for confirmed that since April I not have any other special except the 7/12/11 related to 5. E2 confirms there was no 23/ RN making changes to the specific interventions for R1's status. E2 confirmed that she de any additional evidence of ion made by the Direct als/ DSP in R1's record of edical status or of DSP's tant. I/IDUAL PROGRAM PLAN ram plan states the specific ry to meet the client's needs, comprehensive assessment uph (c)(3) of this section. Is not met as evidenced by: eview and interview the facility ecific objectives for 1 of 1 e sample with rom a swallow evaluation.	W 111			
	identifies R1 as a 7	4 year old individual who ere range of Mental				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN		С	
		14G255	B. WING _			1/2011
NAME OF P	ROVIDER OR SUPPLIER		6	REET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET OYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 227	Syndrome, Esopha Gastroesophageal Discharge Summar 6/13/11 and 7/7/11 hospitalized for Asp. Physician's Orders 7/7/11) states, "Ver Speech Language Swallow Study (dat comments section (patient) swallows a swallow initiation. Fpt begin to show s/s aspiration, recomm performed immedia. In an interview with Director on 8/12/11 that facility did not it to identify objective bite as recommend 6/30/11. 483.460 HEALTH 0	ditional diagnoses of Downs ageal Dyskinsia and Reflux Disease. Ty (local community hospital) of states that R1 was biration Pneumonia. At Time of Transfer (dated y strict aspiration precautions." Pathology Modified Barium ed 6/30/11) under the states, "Must ensure pt after every bite due to delay in eed via teaspoon only. Should ex (signs and symptoms) of end swallow evaluation be ately and discontinue feeding." E2/ Residential Service at 10:26 AM, E2 confirmed mplement an eating program to have R1 swallow after each ed in the Swallow Study of CARE SERVICES	W 227			
	This CONDITION is Based on record refailed to ensure nur adequate nursing e	is not met as evidenced by: eview and interview the facility sing services provided valuation, monitoring and in sample (R1) with sufficient				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUII	DING	G	С	
		14G255	B. WING			08/31/2011	
	ROVIDER OR SUPPLIER			62	EET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET OYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 318	nursing intervention meet the medical not hospitalizations. When facility failed 1) Ensure thorough respiratory status. 2) Follow physician monitor R1's voiding 3) Implement facility (Registered Nurse) in R1's status. 4) Ensure facility has when Direct Support Nurse will contact FR1. 5) Ensure facility has how/ when the RN monitor R1's status recommendations to 6) Ensure nursing his specific intervention Plan/ ISP and upday status changed.	ns and recommendations to eeds resulting in multiple	W 3	:18	DEFICIENCY		
		PM an Immediate Jeopardy ve begun on 4/15/11 when					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SI COMPLE		
	14G255		NG		C 08/31/2011	
NAME OF PROVIDER OR SUPPLI			STREET ADDRESS, CITY, STATE, ZIP C	•	1/2011	
TERRA ESTATES			620 NORTH MAIN STREET HOYLETON, IL 62803			
PREFIX (EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
evaluation, monhad been dischapneumonia. The readmitted to the occurrences of infection and elein an Immediate. On 8/23/11 at 2 notified that the removed. Refer to deficient W331 The facility nursing services 483.460(c) NUF. The facility must services in account of the facility failed to adequate nursing follow up for 1 conversing interver meet the medic hospitalizations. When facility failed to respiratory states.	ensure adequate nursing itoring and follow up for R1 who arged from a hospitalization of ese failures resulted in R1 being e hospital with further pneumonia, sepsis, urinary tract extrolyte imbalance. This resulted e Jeopardy. 35 PM, E1/ Administrator was Immediate Jeopardy was ency cited at: ty must provide clients with an accordance with their needs. RSING SERVICES the provide clients with nursing ordance with their needs. D is not met as evidenced by: cord review and interview the ensure nursing services provided ag evaluation, monitoring and f 3 in sample (R1) with sufficient attions and recommendations to all needs resulting in multiple silled to: ugh nursing evaluation of R1's	Wa				

AND PLAN OF CORRECTION DENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED	
A. BUILDING	С	
14G255 B. WING	08/31/2011	
NAME OF PROVIDER OR SUPPLIER TERRA ESTATES STREET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH MAIN STREET HOYLETON, IL 62803		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
W 331 Continued From page 7 monitor R1's voiding and oral fluid intake. 3) Implement facility's policy on contacting RN (Registered Nurse) Consultant regarding changes in R1's status. 4) Ensure facility has a system which identifies when Direct Support Staff and Licensed Practical Nurse will contact RN Consultant or Physician for R1. 5) Ensure facility has a system which identifies how/ when the RN consultant will evaluate and monitor R1's status so that she/ he may make recommendations to meet R1's medical needs. 6) Ensure nursing has evaluated and identified specific interventions in R1's Individual Service Plan/ ISP and updated R1's ISP as medical status changed. 2. Based on record review and interview the facility failed to ensure preventative care for 1 of 1 individual (R3) identified with a Stage two decubitus ulcer that was acquired at the facility. Findings Include: 1. On 8/12/11 at 2:35 PM an Immediate Jeopardy was identified to have begun on 4/15/11 when facility failed to ensure adequate nursing evaluation, monitoring and follow up for R1 who had been discharged from a hospitalization of pneumonia. These failures resulted in R1 being readmitted to the hospital with further occurrences of pneumonia, sepsis, urinary tract infection and electrolyte imbalance. These failures resulted in an Immediate Jeopardy, E1/		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPI JER/CLIA

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14G255	B. WIN	IG _		C 08/31/2011	
	PROVIDER OR SUPPLIER			6	REET ADDRESS, CITY, STATE, ZIP CODE 320 NORTH MAIN STREET HOYLETON, IL 62803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 331	The Immediate Jeo 8/23/11 at 2:35 PM. Physician's Orders identifies R1 as a 7-functions at the sev Retardation with ad Syndrome, Alzheim Hypercholesterolem Anemia, Gastroeso Chronic Obstructive Procedure Pacema of Gastric Resection Review of docume (R1's name)" (unda Licensed Practical I states that R1 was Admit 4/11/11 Discipneumonia Admit 5/7/11 Discipneumonia Admit 6/7/11 Discipneumonia Admit 6/29/11 Discipneumonia / Sepis Admit 7/19/11 Discipneumonia / Sepis	notified on 8/12/11 at 2:35 PM. pardy was removed on (POS) of 7/1/11- 7/31/11 4 year old individual who be re range of Mental ditional diagnoses of Downs er's, Hypothyroidism, nia, Esophageal Dyskinsia, phageal Reflux Disease, e Pulmonary Disease, Surgical ker Insertion and Past History n. Int titled, "Hospitalizationsted) given to surveyor by E3/Nurse on 8/10/11 at 2:15 PM, hospitalized as follows: Charged 4/15/11 Diagnosis: Charged 6/13/11 Diagnosis: Charged 7/7/11 Diagnosis: Charged 7/22/11 Diagnosis:	W	331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	IG	С	
		14G255	B. WING _			1/2011
	ROVIDER OR SUPPLIER		6	REET ADDRESS, CITY, STATE, ZIP CODE 520 NORTH MAIN STREET HOYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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
W 331	local hospital for ho 4/11/11-7/22/11) star Pneumonia on 4/11 6/29/11. Review of R1's Nurthe only documental status was on 4/10/Clear." and on 4/10 respiratory difficultie evidence of nursing lung sounds. R1's Nursing Notest entries: 4/11/11 8:00 AM- "Frespiratory distress without assist. Swellankle." 4/11/11 9:00 AM- "7 (emergency Room) 4/11/11 1:20 PM- "Adiagnosis) pneumond 4/15/11 5:00 PM- Frespiratory distress without assist. Swellankle."	Discharge Summary's from spitalizations (dated ates that R2 was admitted for /11, 5/7/11, 6/7/11 and sing Notes 3/25/11- 4/10/11, ation of assessing respiratory 11 at 8:30 AM stating, "Lungs /11 at 4:00 PM stating, "No es." There was no other athoroughly assessing R1's continues with the following Bilateral Wheezing noted -no noted. Weak- unable to stand lling noted (right) calf and To (local hospital) for ER evaluation per car."	W 331			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G255	B. WIN	G			C 1/ 2011
NAME OF PE	ROVIDER OR SUPPLIER STATES			62	EET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH MAIN STREET OYLETON, IL 62803		
(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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	effective.) Reviewed Nurses N the following docume valuating R1's research of the following docume valuating R1's research of the following R1's research of the following R1's research of the following R1's R1's R1's Nurse's Notes R1's AM "Resplated AM "First responde R1's AM "Resplated following R1's Nurse's Notes on 50 R1 was admitted by hospital with a diagond Pneumonia. R1	lional assessment v or if the treatment was lotes 4/16/11-5/6/11 with only nentation of nursing	W3	331			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		14G255	B. WING			C 08/31/2011	
	ROVIDER OR SUPPLIER			(REET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH MAIN STREET HOYLETON, IL 62803	1 33/3	1/2011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 331	slightly congested, on noted." Review of Nurse"s if following document lung sounds to assessatus: 5/18/11 12:00 (noor cough with (right) sit 5/19/11 8:00 AM- "Vupper lobe" 5/20/11 8:00 AM- "Vupper lobe" 5/21/11 8:20 AM- "Funresponsive, droof extremity. Pulse ox to ER (emergency romainity hospital seizures Pulse of (occasional congested cough at No evidence of writt nursing assessed romainity staff notified physician for recommendation."	Notes (5/17/11-6/7/11) has the ation of nursing auscultating ess thoroughly R1's respiratory n) "Occ (occasional) moist ided wheeze noted." Wheeze/ rub noted (right) no) wheezing noted to upper (oximetry) 89%. Transported from) per ambulance." Returned from)local 1) Drowsy. Received med's for ox 82% Lungs clear, occ ted cough)." se Ox (oximetry) 89% Loose times." ten documentation that respiratory status thoroughly ing lung sounds from 5/23/11-no written evidence that the the RN consultant or	W	331			
		-					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPI JER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		14G255	B. WIN	1G _		C 08/31/2011	
NAME OF P	ROVIDER OR SUPPLIER			6	REET ADDRESS, CITY, STATE, ZIP CODE 320 NORTH MAIN STREET HOYLETON, IL 62803		.,,2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPRICE OF THE	JLD BE	(X5) COMPLETION DATE
W 331	(continue)." 6/7/11 9:00 AM- "To (follow up) (arrow p appetite and fluid in community hospital Facility document tiname)" (no date) st 6/7/11- 6/13/11 for a 6/13/11 7:00 AM- "F Support Profession PM at 8:30 PM productive" 6/13/11 1:00 PM- (r Resp (respiration) 1 loose moist cough.' Review of Nurse's N is no evidence that respiratory status througs. R1's Nurse's Notes 6/29/11 2:30 PM-"F diaphoretic unrespondence to (local 6/29/11 (no time) - 1/2 (10 cm) appetite to (local 6/29/11 (no time) - 1/2 (10 cm) appetite and fluid in the following in the fo	Lungs congested bil eathing) treatment cont o (physician's office) for FU ointing down/ decreased) take. Transferred to (local) via ambulance." tled "Hospitalizations - (R1's ates that R1 was hospitalized aspiration pneumonia. Reported by DSP (Direct al) - readmitted to facility lastmoist cough noted- non no) respiratory distress noted. 16- shallow continues to have Notes (6/14/11- 6/28/11) there nursing assessed R1's noroughly by auscultating states the following:	W	331			
	(130ai ooiiiiiiaiiiiy ii	Sopriar, Will Dr. (diagnosis) of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUIL	.DING		, ا	C
		14G255	B. WIN	G		08/31/2011	
	PROVIDER OR SUPPLIER			620	ET ADDRESS, CITY, STATE, ZIP CODE O NORTH MAIN STREET DYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	contacted the RN obeing sent out by an Facility document tiname)" (no date) st 6/29/11-7/7/11 for Review of Nurse's Notes following document lung sounds: 7/17/11 4:00 PM-"Lough at times." 7/22/11 4:30 PM-"Lough at times." 7/23/11 9:00 AM-"Lough and the resident was well Gurgling heard in being Encouraged to cough. There was no further nursing assessed Following: Notes following:	Breath)." De that the facility staff or the Physician prior to R1 mbulance. Itled "Hospitalizations - (R1's rates that R1 was hospitalized pneumonia/ sepsis. Notes (7/7/11-8/1/11) has the ration of nursing auscultating auscultating auscultating rungs congested today, loose Lungs moist sounds. Non Lung sounds diminished." "DSP reported to this nurse theezing. Lungs checked. oth lower lobes.Repositioned."	W 3	31			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		14G255	B. WIN	NG _			C 1/ 2011
	ROVIDER OR SUPPLIER		•	6	REET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH MAIN STREET HOYLETON, IL 62803	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ULD BE	(X5) COMPLETION DATE
W 331	(Ambulance) called community hospital 8/3/11 late entry- "A hospital) 8/2/11 with abnormalities" In an interview with on 8/11/11 at 11:35 documentation regastatus would be four confirmed that she that nursing assess thoroughly by auscuthat Z3/Registered respiratory status of assessment. E3 conton provide written entre RN Consultant for R1 to obtain furting interventions to proprevent further hospitalizations with 8/12/11 at 3:16 PM expect the Licensed facility to assess respiratory shift they are there expect the LPN's to assess respiratory signed assess respiratory signed assess respiratory signed of changes stated "Yes."	coted- slow to respond for transport to (local)." Admitted to (local community of DX (diagnosis) of breathing E3/ Licensed Practical Nurse AM, E3 stated that all arding assessing respiratory ond in the Nursing Notes. E3 has no other written evidence ed R1's respiratory status cultating lung sounds. E3 stated Nurse would assess R1's once a year with the annual onfirmed that she was unable ovidence that she had called oregarding health care issues her recommendations/ ovide for R1, to potentially	W	331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G	(C
		14G255	B. WING _		08/3	1/2011
	PROVIDER OR SUPPLIER ESTATES		6	REET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET IOYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	"Encourage fluids frurine output or contour In review of R1's N 7/19/11) for written of R1's voiding, the documented that st on 7/7/11 and 7/14/ In review of R1's N 7/19/11) nursing did daily oral fluid intak amounts to assess intake was. R1's Nurse's Notes following, "To (physup) appointment. So from (physician's of (related to) dehydrated to) dehydrate Facility document tiname)" (no date) st 7/19/11- 7/22/11 for Electrolyte Imbalantin In an interview with 8/16/11 at 9:34 AM status when brough stated, "R1 had modistress, diarrhea the eating bites. I flat on her here." Z3 confir been taken directly required 24 hour nurse.	ler recommendations states, requently, report decreased inued poor fluid intake." urse's Notes (5/24/11-evidence of facility monitoring re was only two entries ated, "voided good amount" 11. urse's Notes (5/24/11-d) not document what R1's e in consistent measurable what R1's total daily fluid dated 7/19/11 state the dician's office) for F/U (follow ent to ER (emergency room) fice) for evaluation R/T existion. Itled "Hospitalizations - (R1's ates that R1 was hospitalized for Urinary Tract Infection/ce. Z2/ Nurse Practitioner on when asked about R1's at to the office on 7/19/11, Z2 ttling of the skin, respiratory brough the weekend, only ut asked, why did you bring med that E1 should have to hospital and that E1	W 331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		14G255	B. WING			C 1/ 2011
	PROVIDER OR SUPPLIER		6	REET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET IOYLETON, IL 62803	<u> </u>	1/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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
W 331	expect staff to do re to monitor R1's void stated, "They could measure intake. The many cc's there are confirmed that she to record R1's voids nurse practitioner's In an interview with Nurse) on 8/11/11 at three ring binder and documentation of Review of the book consistent documentations. Notes would be the of R1's voiding wou provide any further R1's voiding outside Nurse's Notes for 7 3) Facility's Policy to (Registered Nurse) states the following "When should I cord. Any significant cl. 5. When the individing appears to be ill.	when asked what she would elated to the recommendation ding and oral fluid intake, Z3 count R1's attends and ley could show DSP's how is in different items." Z3 would expect direct care staff and oral fluid intake as per recommendations. E3/ LPN (Licensed Practical let 11:35 AM, E3 gave surveyor from the kitchen area that had oral intake of residents. A provided, there was no intation of what R1's daily oral per Nurse Practitioner's E3 confirmed that the Nurse's only place that documentation of let be found. E3 was unable to evidence of documentation of let of the two entries made in 1/7/11 and 7/14/11. Ittled, "Contacting RN protocol" (dated March 2007): Intact the RN?"	W 331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BU	LDIN	G	ا ا	c
		14G255	B. WII	NG			1/ 2011
	ROVIDER OR SUPPLIER			62	EET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET OYLETON, IL 62803		
(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
W 331	(R1's name)" (unda Licensed Practical I states that R1 was 5/7/11, 6/7/11, 6/29 for Urinary Tract Inf Respiratory Abnorm In an interview with on 8/11/11 at 11:35 contacts Z3/ RN, E3 I'll call her by phone would document con Nurses Notes." Wh notified of hospitali visits or changes in know through There communication systomes and notify Z3 promunication. E3 unable to provide e changes in R1's merecommendations. In an in an interview 8/11/11 at 12:06 PN notifies her of changes in R1's merecommendations. In an in an interview 8/11/11 at 12:06 PN notifies her of changes in R1's states "This home in doctor's visits and easked if LPN's come changes in R1's states "This home in doctor's visits and easked if LPN's come changes in R1's states "We don't do Direct Support Profits of the states	nt titled, "Hospitalizations- ited) given to surveyor by E3/ Nurse on 8/10/11 at 2:15 PM, hospitalized on 4/11/11, //11 for Pneumonia, 7/19/11 fection and 8/2/11 for halities. E3/ Licensed Practical Nurse AM, when asked when she stated, "If I have a question, e." When asked where she mmunications with RN, "In the en asked how the RN is zations, Emergency Room R1's status,states "She would up (computer based tem). E3 confirmed that she	W:	331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN		(c
		14G255	B. WING _		08/3	1/2011
	PROVIDER OR SUPPLIER		6	REET ADDRESS, CITY, STATE, ZIP CODE 520 NORTH MAIN STREET HOYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	Director on 8/12/11 documentation of I and LPN's contacti residents health sta she'll tell them what she was unable to pDSP's and LPN'S cpolicy. 4) Facility's Policy ti (Registered Nurse) states the following "When should I con 3. Anytime vital sign 4. Any significant ch 5. When the individ appears to be ill. 6. Anytime someon from the hospital. 9. Anytime you feel individual's situation individual's disease 13. Anytime you feel individual is not bein Please Note: Keep calls. It will help with documentation with know what is going contacted on. It will information if the Ri on your shift.	E2/ Residential Service at 10:26 AM, when asked for Direct Support Professionals ng RN for changes in Itus states, "They will call and it to do." E2 confirmed that provide written evidence of ontacting the RN as per facility thed, "Contacting RN protocol" (dated March 2007): Itact the RN?" Inside are not within normal limits. It hange in condition. It will be a susual, or the is hospitalized or discharged uncomfortable with an or have questions about an or condition. It is a medical problem with an in a medical problem with a medical problem wi	W 331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN		(C
		14G255	B. WING _		08/3	1/2011
	PROVIDER OR SUPPLIER		6	REET ADDRESS, CITY, STATE, ZIP CODE 120 NORTH MAIN STREET HOYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	clearly identify who policy does not ider RSD will contact the identify who will corstatus changes prices of that interventions a possible hospitalistate where staff arwith RN or where the made by staff and had called Phychanges in R1's staff had called Phychanges in R	will contact the RN. This will contact the RN. This will contact the RN. This will policy does not the RN. This policy does not will act the physician if R1's will to a scheduled appointment of the RN. The policy does not the end of the policy does not the policy does not the end of the policy does not the policy does not be policy does not the policy does not be policy does not the policy doe	W 331			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		14G255	B. WIN	1G _			C 1/ 2011
	PROVIDER OR SUPPLIER			6	REET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH MAIN STREET HOYLETON, IL 62803	00,0	.,2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPRICED TO THE APPRICED TO THE APPRICED OF THE APPRICED O	ULD BE	(X5) COMPLETION DATE
W 331	8/2/11) their was not by the RN or of the regarding changes R1's Quarterly Nurse by the E3/ LPN for of There was no evide had reviewed the quast they were done. In review of R1's H7/7/11) there was note evaluated or monited. In interviews with Zi and 8/12/11 at 3:16 assess R1 when shospital, Z3 stated asked when she we stated, "With the ardid a physical asses" Once a year with the amonth before the whole record. I review consults everything confirmed that she labs, consults, discolute they changed, but of the labs o	Nurse's Notes (4/11/11- o written documentation made staff reporting to the RN in R1's status. Sing Reviews where completed 6/17/11, 3/15/11 and 12/9/10. Ence that the RN consultant carterly nursing assessments Hospital Discharges (4/15/11-o evidence that the RN had ored R1's medical status. 3/ RN on 8/11/11 at 12:06 PM PM, when asked who would be was discharged from the could review R1's consults, Z3 inual." When asked when she assment of R1, Z3 stated, the annual." Z3 stated, the annual is due, I review the ew all the quarterlies, labs, that's in the record." Z3 did not review quarterlies, harges as they occurred or as once a year at the annual. Z2/ Nurse Practitioner on when asked if she would informed of R1's status so take recommendations and	W	331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G	ر ا	
		14G255	B. WING _			1/2011
	ROVIDER OR SUPPLIER		6	REET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET HOYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	Director/ RSD on 8 8/24/11 at 9:06 AM system on how the evaluates and mon "The RN does year the month before the record." E2 further special staffing's for a special staffing's for a special staffing for that since April 201 other special staffing related to R1's med 6) R1's Individual States the following "Recommendations" Monitor for cardial and report to nurse "Due to history of Umonitor for symptom Review of R1's ISF specifically identify monitor. The reconspecifically identify respiratory, and uring symptoms that the are to monitor and Consultation Form (dated 5/24/11) und "Encourage fluids for urine output or confidence of the system of R1 is ISF specifically identify respiratory, and uring symptoms that the are to monitor and consultation Form (dated 5/24/11) und "Encourage fluids for urine output or confidence in the system of R1 is ISF specifically identify respiratory, and uring symptoms that the are to monitor and consultation Form (dated 5/24/11) und "Encourage fluids for urine output or confidence in the system of R1 is ISF specifically identify respiratory and uring symptoms that the are to monitor and consultation Form (dated 5/24/11) und "Encourage fluids for urine output or confidence in the system of R1 is ISF specifically identify respiratory and uring symptoms that the are to monitor and consultation for monitor and confidence in the system of R1 is ISF specifically identify respiratory and uring symptoms that the are to monitor and confidence in the system of R1 is ISF specifically identify respiratory and uring symptoms that the are to monitor and confidence in the system of R1 is ISF specifically identify respiratory and uring symptoms that the are to monitor and confidence in the system of R1 is ISF specifically identify respiratory and uring symptoms that the are to monitor and confidence in the system of R1 is ISF specifically identify respiratory and uring symptoms that the are to monitor and its ISF specifically identify respiratory and uring symptoms that the are to monitor and its	E2/ Residential Service B/11/11 at 12:21 PM and , when asked the facility's RN/ Registered Nurse itors R1's status, E2 stated ly assessments, she'll come in ne annual and will review R1's stated that the RN will attend or individuals and that they had or R1 on 7/12/11. E2 confirmed 1, the facility did not have any ng meetings except the 7/12/11 lical status. ervice Plan (dated 10/6/10) under section titled S": c and respiratory symptoms ." JTI (urinary tract infection), ms of urinary tract infection." P of 10/6/10 does not what direct care staff are to nmendations do not what type of cardiac, nary tract infection signs and Direct Support Professional	W 331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN		(C
		14G255	B. WING _		08/3	1/2011
	PROVIDER OR SUPPLIER		6	REET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET HOYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	health. She has been in the last six month frequent. She is use pneumonia	ly R1 has had a change in her en hospitalized several times as and it's starting to be more ually hospitalized for aspirationHer liquids must be of to ensure that she does not to to have her food pureed for he does require prompting to I not feed herself. Staff do eding her when she is ntake has been poor and staffer to eat." of 7/12/11 does not state any made by the RN of specific 's change in medical status ultation of 5/24/11 or the m 4/11/11- 7/7/11. Notes (4/11/11-8/2/11), R1's /11-7/29/11) and Hospital y/ Instructions here is no documentation ered Nurse of any further of interventions made related	W 331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN		(C
		14G255	B. WING _		08/3	1/2011
	ROVIDER OR SUPPLIER		6	REET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET HOYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 331	2011, the facility did staffing meetings ex R1's medical status other evidence of ZR1's ISP related to change in medical status of the revidence of ZR1's ISP related to change in medical status of the status of t	confirmed that since April of not have any other special except the 7/12/11 related to so E2 confirms there was no E3/RN making changes to the specific interventions for R1's estatus. The status of the status of the specific interventions for R1's estatus. The status of the status of the specific interventions for R1's estatus. The status of the s	W 331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SURVEY COMPLETED	
		14G255	B. WIN	IG		08/ 3 1	C 1/ 2011
	ROVIDER OR SUPPLIER			62	EET ADDRESS, CITY, STATE, ZIP CODE 0 NORTH MAIN STREET DYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
W 331	review all quarterlie and labs. The RN will review specific signs and signs are listed section of the nurse and LPN's understato report to the RN. The RN will train Rispecific things to losymptomology for expecific things and time the physician if app the date and time the physician if app the date and time the information being recommendations to log shall be reviewed scheduled visit to the on the log sheet to contacted at the time reviewed and will proposed in the residents file to will assist with qual documentation as we other staff on other on and what the RN and the staff on other on and what the RN and the residents file to will assist with qual documentation as we other staff on other on and what the RN and the residents file to will assist with qual documentation as we other staff on other on and what the RN and the RN and the reviewed and will proposed to the residents file to will assist with qual documentation as we other staff on other on and what the RN and the RN an	all IPP's to ensure that symptoms related to each in the recommendation and what to look for and what so that both DSP's and what to look for and what so the facility. The RN will sign off indicate that she was ne of the incident and has rovide any necessary follow-up y of the log will be placed in ensure continuity of care. This	W	331			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUI	LDIN	G		
		14G255	B. WI	IG			1/2011
	ROVIDER OR SUPPLIER			62	EET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET OYLETON, IL 62803		
(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
W 331	compliance at the tinot had the opportue evaluate the effective. 2. The facility failed for 1 of 1 individual II/ III decubiti ulcer facility. Physician's Orders/identify R3 as a 82 functions at the Sex Retardation with ad Diabetes Mellitus T states that R1 utilizand requires assist R3's Consultation F Findings states, "St (left) buttock." R3's Consultation F 1)Cleanse (left) but saline) 2)Apply Sar Wound Clinic Problem R3 in for evaluation buttock measuringThe area is incepale erythema is not directionsSr surrounding eryther drainage."	the facility remains out of time of exit, as the facility has inity to fully implement and veness of their plan. If to ensure preventative care all (R3) identified with a Stage that was acquired at the IPOS (dated 8/1/11- 8/31/11) year old individual who vere range of Mental ditional diagnoses of Anemia, ype II and Edema. The POS es a wheelchair for mobility of two for transfers. Form (dated 7/28/11) under age II/ III pressure ulcer to Form (dated 8/1/11) states, "tocks wound with (normal ntyl to black necrotic tissue." The List (dated 8/1/11) states, on of a decubitus on the left 0.7 x 1.1 x indeterminate. It durated surrounding it and otted for about 1 cm in all ne has an eschar with ma as described above. No E3/ Licensed Practical Nurse	W	331			
		PM, E3 confirmed that R2 itus ulcer to left hip while					

AND PLAN OF CORRECTION (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		14G255	B. WIN	NG _			C 1/ 2011
NAME OF P	ROVIDER OR SUPPLIER			6	REET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH MAIN STREET HOYLETON, IL 62803	00/3	1/2011
(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
W 331 W9999	receiving care at thi	is facility. IONS	W 3				
	350.620a) 350.1210 350.1220j) 350.1230d)1) 350.3240a) 350.3750						
	Section 350.620 Re	esident Care Policies					
	procedures governi facility which shall be involvement of the a shall be available to public. These writte	have written policies and ng all services provided by the performulated with the administrator. The policies of the staff, residents and the n policies shall be followed in and shall be reviewed at					
	Section 350.1210 H	lealth Services					
		ovide all services necessary to lent in good physical health.					
	Section 350.1220 P	Physician Services					
	of any accident, injucondition that threat welfare of a resider the presence of incidents.	notify the resident's physician ury, or change in a resident's tens the health, safety or at, including, but not limited to, ipient or manifest decubitus oss or gain of five percent or d of 30 days.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILD		С	
		14G255	B. WING			1/2011
	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH MAIN STREET HOYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	are not limited to, the 1) Detecting signs of maladaptive behavioursing or psychosol. Section 350.3240 All all An owner, license agent of a facility shresident. (Section 2) Section 350.3750 Chursing Services Residents needing to an ICF/DD of 16 has adequate profes meet the resident's made through formal a licensed nurse to responsible staff metimes who is immediately whom residents carillness, and emerged 350.810(all). The consultation on the individual plan of canot less than two hor these Regulations by: Based on record refailed to ensure nurse.	dursing Services Innel shall be trained in, but the following: of illness, dysfunction or or that warrant medical, ocial intervention. Industry and Neglect thee, administrator, employee or hall not abuse or neglect a 107 of the Act) Consultation Services and The facility assional nursing services to needs. Arrangements shall be all contract for the services of visit as required. A the medical services in the services of or report injuries, symptoms of the contract for the services of or report injuries, symptoms of the contract for the services of or report injuries, symptoms of the contract for the services of or report injuries, symptoms of the contract for the services of or report injuries, symptoms of the contract for the services of the	W999	9		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G	(
		14G255	B. WING _			1/2011
	ROVIDER OR SUPPLIER		6	REET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET HOYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	nursing intervention meet the medical n hospitalizations who are the medical n hospitalizations who are the medical n hospitalizations who are the monitor R1's voidin and are the monitor R1's voidin and are the monitor R1's status. 4) Ensure facility has when Direct Support Nurse will contact FR1. 5) Ensure facility has when Direct Support Nurse will contact FR1. 5) Ensure facility has monitor R1's status recommendations to a monitor R1's status recommendations to a monitor R1's pand update thanged. Findings Include: Physician's Orders identify R1 as a 74 functions at the seven Retardation with ad Syndrome, Alzheim	in sample (R1) with sufficient and recommendations to eeds resulting in multiple	W9999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUIL			(С
		14G255	B. WIN	G		08/3	1/2011
NAME OF P	ROVIDER OR SUPPLIER			62	EET ADDRESS, CITY, STATE, ZIP CODE O NORTH MAIN STREET OYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	Anemia, Gastroeso Chronic Obstructive Procedure Pacema of Gastric Resectio Review of docume (R1's name)" (unda Licensed Practical I	phageal Reflux Disease, e Pulmonary Disease, Surgical ker Insertion and Past History n. nt titled, "Hospitalizations- ited) given to surveyor by E3/ Nurse on 8/10/11 at 2:15 PM,	W99	99			
		hospitalized as follows: charged 4/15/11 Diagnosis:					
	Admit 5/7/11 Discl Pneumonia	harged 5/16/11 Diagnosis:					
	Admit 6/7/11 Disch Aspiration Pneumo						
	Admit 6/29/11 Discl Pneumonia / Sepis	harged 7/7/11 Diagnosis:					
		charged 7/22/11 Diagnosis: ion/ Electrolyte Imbalance					
	Admit 8/2/11 (no di hospitalized as of 8 Abnormalities	ischarge date/ remains /17/11) Respiratory					
	local hospital for ho 4/11/11-7/22/11) sta	Discharge Summary's from spitalizations (dated ates that R2 was admitted for /11, 5/7/11, 6/7/11 and					
	the only documenta	sing Notes 3/25/11- 4/10/11, ation of assessing respiratory 11 at 8:30 AM stating, "Lungs					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILE		-	С	
		14G255	B. WING	§		1/2011	
	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP 620 NORTH MAIN STREET HOYLETON, IL 62803	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
W9999	respiratory difficultie evidence of nursing lung sounds.	/11 at 4:00 PM stating, "No es." There was no other thoroughly assessing R1's	W999	99			
	R1's Nursing Notes entries:	continues with the following					
	respiratory distress	Bilateral Wheezing noted -no noted.Weak- unable to stand lling noted (right) calf and					
		Fo (local hospital) for ER evaluation per car."					
	4/11/11 1:20 PM- "Adiagnosis) pneumo	Admitted to (hospital with nia."					
	continue same med daily, (2) Zpack (Zit times 4 days, (3) C times 5 days (4) Ne albuterol. Ipratropiu while awake and Pf congested (with) ra Nebulizer tre (There was no addi	Readmit to Terra Estatesto Is and add (1) Plavix 75 mg hromycin) 3 pack 250 mg reftin 500 mg BID (twice a day) rebulizer tx (treatment) m Bromide (every 6 hours RN (as needed)Lungs respy occasional cough. reatment given per order." tional assessment w or if the treatment was					
		Notes 4/16/11-5/6/11 with only nentation of nursing spiratory status:					
		ocumentation AM or PM) Has occasional cough."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BU	ILDIN	G	١ ,	_
		14G255	B. WII	NG _		C 08/31/2011	
	ROVIDER OR SUPPLIER			6	REET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET OYLETON, IL 62803		
(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
W9999	Continued From pa	ge 31	W9	999			
		PM) "Occasional cough treatment given at noon"					
	4/1811 8:00 AM- "m productive."	noist cough noted non					
	respiratory status o nebulizer treatment additional nebulizer	ntation of assessing R1's r response to ordered or the need to provide treatments documented in from the 4/19/11 to 5/6/11.					
	"Resident stood up and collapsed. Res rolled back, irreg (ir 9:40 AM "Resp labo AM "First responde 74%. Applied (oxyg	on 5/7/11 state, 9:30 AM, from seated position on couch ident unresponsive, eyes regular) resp (respiration)." ored but not irregular." 9:50 r here pulse ox (oximetry) en) (increased) pulse ox 84%" ed to (local community					
	R1 was admitted ba hospital with a diag and Pneumonia. R1 med Flagyl 500mg times five days. Nu	/16/11, in summary, state that ack to Terra Estates from the nosis of Clostridium Difficile I was sent home with new by mouth every eight hours rse documented, "Lungs occ (occasional) cough					
	following document	Notes (5/17/11-6/7/11) has the ation of nursing auscultating ess thoroughly R1's respiratory					
	5/18/11 12:00 (nooi	n) "Occ (occasional) moist					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BU	LDIN	G	С	
		14G255	B. WII	NG _		08/31/2011	
	ROVIDER OR SUPPLIER			62	EET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET OYLETON, IL 62803		
(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
W9999	5/19/11 8:00 AM- "Vupper lobe." 5/20/11 8:00 AM- "(5/21/11 8:20 AM- "Funresponsive, droo extremity. Pulse ox to ER (emergency in the seizures Pulse of (occasional congested cough at the seizures of	ided wheeze noted." Wheeze/ rub noted (right) Thooly wheezing noted." Found per staff member ling fine jerking noted to upper (oximetry) 89%. Transported from) per ambulance." Returned from)local) Drowsy. Received med's for ox 82% Lungs clear, occ ted cough)." See Ox (oximetry) 89% Loose times." Iten documentation that respiratory status thoroughly ng lung sounds from 5/23/11-no written evidence that the the RN consultant or mendations. states the following: Lungs congested bil eathing) treatment cont or (physician's office) for FU ointing down/decreased) utake. Transferred to (local	W9	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						C
		14G255	B. WING		08/3	1/2011
	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH MAIN STREET HOYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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
W9999	Facility document tiname)" (no date) st 6/7/11- 6/13/11 for 6/13/11 7:00 AM- "F Support Profession PM at 8:30 PM productive" 6/13/11 1:00 PM- "(Resp (respiration) 1 loose moist cough.' Review of Nurse's Notes of Nurse's Notes with the spiratory status the spiratory sta	tled "Hospitalizations - (R1's ates that R1 was hospitalized aspiration pneumonia. Reported by DSP (Direct al) - readmitted to facility lastmoist cough noted- non (no) respiratory distress noted. (16- shallow continues to have ') Notes (6/14/11- 6/28/11) there nursing assessed R1's noroughly by auscultating states the following: Reported by staff- in reclineronsive." Responders (911) at facility community hospital)." "DSP reports admitted to ospital) with Dx (diagnosis) of Breath)." the that the facility staff in the Physician prior to R1 mbulance. tled "Hospitalizations - (R1's ates that R1 was hospitalized.)	W9999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN			С
		14G255	B. WING _		08/3	1/2011
TERRA E	ROVIDER OR SUPPLIER		6	REET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET IOYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	following document lung sounds: 7/17/11 4:00 PM- "I cough at times." 7/22/11 4:30 PM- "I productive cough." 7/23/11 9:00 AM- "I 7/24/11 16:50 PM- that resident was w Gurgling heard in b Encouraged to cough. There was no furthenursing assessed F thoroughly by ausci 8/1/11. There was recontacted the RN or recommendations. R1's Nurse's Notes following: 8/2/11 1:00 PM- "C (bilateral) wheeze recommendations. 8/3/11 late entry- "A 8/3/11 late entry-" A 8/3/11 late entry-" A 1/2 C 1	Notes (7/7/11-8/1/11) has the ration of nursing auscultating Lungs congested today, loose Lungs moist sounds. Non Lung sounds diminished." "DSP reported to this nurse heezing. Lungs checked. oth lower lobes.Repositioned. gh frequently." er written documentation that R1's respiratory status cultating lungs from 7/7/11-no evidence that facility staff or the Physician for further dated 8/2/11 states the longested- loose cough bill noted- slow to respond	W9999	DEI IOIENCT)		
	abnormalities"	n DX (diagnosis) of breathing E3/ Licensed Practical Nurse				
		AM, E3 stated that all				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BU	LDING	G		
		14G255	B. WII	NG			1/2011
	ROVIDER OR SUPPLIER			62	EET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET OYLETON, IL 62803		
(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
W9999	status would be four confirmed that she that nursing assess thoroughly by auscit that Z3/Registered respiratory status or assessment. E3 cort to provide written end the RN Consultant for R1 to obtain further ecommendations/if to potentially prevent to potentially prevent in an interview with 8/12/11 at 3:16 PM expect the Licensed facility to assess respiratory shift they are there, expect the LPN's to assess respiratory shift they are there, expect the LPN's to assess respiratory shift do for changes stated "Yes." 2) Consultation For (dated 5/24/11) und "Encourage fluids for urine output or continue output or continue output or continue of R1's voiding, the	arding assessing respiratory nd in the Nursing Notes. E3 has no other written evidence ed R1's respiratory status ultating lung sounds. E3 stated Nurse would assess R1's nce a year with the annual nfirmed that she was unable vidence that she had called regarding health care issues her interventions to provide for R1, nt further hospitalizations. Z3/Registered Nurse on when asked what she would depractical Nurses at the garding R1's history of in Pneumonia, Z3 stated, a status and document every when asked if she would a auscultate R1's lungs to status thoroughly, Z3 stated if she felt she should be in R1's medical status, Z3 m with Z2/Nurse Practitioner der recommendations states, requently, report decreased inued poor fluid intake." urse's Notes (5/24/11-evidence of facility monitoring re was only two entries ated, "voided good amount"	W9	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	A. BUILDING		COMPLETED	
		14G255	B. WIN	NG _			C 1/ 2011
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH MAIN STREET HOYLETON, IL 62803	30,0	.,
(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
W9999	In review of R1's N 7/19/11) nursing did daily oral fluid intak amounts to assess intake was. R1's Nurse's Notes following, "To (physup) appointment. Sofrom (physician's of (related to) dehydra: Facility document tiname)" (no date) st 7/19/11- 7/22/11 for Electrolyte Imbaland In an interview with 8/16/11 at 9:34 AM status when brough stated, "R1 had modistress, diarrhea the eating bites. I flat on her here." Z2 confir been taken directly required 24 hour nurse in the eating bites at 18/12/11 at 3:16 PM expect staff to do reto monitor R1's voic stated, "They could measure intake. The many cc's there are confirmed that she in the service of th	urse's Notes (5/24/11-d not document what R1's e in consistent measurable what R1's total daily fluid dated 7/19/11 state the dician's office) for F/U (follow ent to ER (emergency room) fice) for evaluation R/T dition. tled "Hospitalizations - (R1's eates that R1 was hospitalized for Urinary Tract Infection/dec. Z2/Nurse Practitioner on when asked about R1's dit to the office on 7/19/11, Z2 dettling of the skin, respiratory brough the weekend, only dut asked, why did you bring med that R1 should have to hospital and that R1 desired care. Z3/ Registered Nurse on when asked what she would delated to the recommendation ding and oral fluid intake, Z3 count R1's attends and ey could show DSP's how a in different items." Z3 would expect direct care staff and oral fluid intake as per	W99	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
						С	
		14G255	B. WING	IG	08/3	1/2011	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH MAIN STREET HOYLETON, IL 62803			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE	
W9999	In an interview with Nurse) on 8/11/11 a a three ring binder of documentation of of the book provided documentation of was as per Nurse Frecommendations. Notes would be the of R1's voiding wou provide any further R1's voiding outside Nurse's Notes for 7 3) Facility's Policy ti (Registered Nurse) states the following "When should I conda. Any significant change of the individing appears to be ill. 6. Anytime someon from the hospital. Review of docume (R1's name)" (unda Licensed Practical I states that R1 was 5/7/11, 6/7/11, 6/29 for Urinary Tract Inf Respiratory Abnorman In an interview with	E3/ LPN (Licensed Practical at 11:35 AM, E3 gave surveyor from the kitchen area that had ral intake of residents. Review ed, there was no consistent that R1's daily oral fluid intake practitioner's E3 confirmed that the Nurse's only place that documentation lid be found. E3 was unable to evidence of documentation of e of the two entries made in the titled, "Contacting RN protocol" (dated March 2007): The tact the RN?" The titled, "Hospitalizations—the distributed or discharged in the titled, "Hospitalizations—the distributed on the titled, "Hospitalizations—the distributed on 4/11/11, the protocol of the two entries made in the titled, "Hospitalizations—the distributed or discharged in the titled, "Hospitalizations—the distributed on 4/11/11, the protocol of the two entries made in the titled, "Hospitalizations—the distributed or discharged in the titled, "Hospitalizations—the distributed on 4/11/11, the protocol of the two entries made in the titled, "Hospitalizations—the distributed or discharged in the titled, "Hospitalizations—the distributed or discharged in the titled, "Hospitalizations—the distributed or discharged in the titled, "Hospitalizations—the distributed in the titled, "Hospitalizations—the distributed in the titled, "The protocol of the two entries made in the titled, "The protocol of the two entries made in the titled, "The protocol of the two entries made in the titled, "The protocol of the two entries made in the titled, "The protocol of the two entries made in the titled, "The protocol of the two entries made in the titled, "The protocol of the two entries made in the titled, "The protocol of the two entries made in the titled, "The protocol of the two entries made in the titled, "The protocol of the two entries made in the titled, "The protocol of the	W999	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		14G255	B. WIN	NG _			C 1/ 2011
	ROVIDER OR SUPPLIER			6	REET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH MAIN STREET HOYLETON, IL 62803		.,
(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
W9999	contacts Z3/ RN, E3 I'll call her by phone would document co Nurses Notes." Wh notified of hospitali visits or changes in would know through communication sys does not notify Z3 p communication. E3 unable to provide e changes in R1's me recommendations. In an in an interview 8/11/11 at 12:06 PN notifies her of change in R1's they call per telephoral doctor's visits and easked if LPN's communication." When a documented, Z3 stated "This home in doctor's visits and easked if LPN's communication." When a documented, Z3 stated with call per telephoral documented, Z3 stated in an interview with Director on 8/12/11 documentation of D and LPN's contaction residents health state and she'll tell them that she was unable	B stated, "If I have a question, e." When asked where she mmunications with RN, "In the en asked how the RN is zations, emergency room R1's status, E3 stated "She Therup (computer based tem). E3 confirmed that she per direct verbal confirmed that she was vidence of notifying Z3 of edical status to get further with X3/ Register Nurse on M, when asked how facility ges in R1's status, Z3 stated d E-mail." When asked how of changes in R1's status, Z3 stated d E-mail." When asked how of changes in R1's status, Z3 stated "Sometimes one with changes and sked where this would be atted "We don't document." Direct Support Professionals as in R1's status, Z3 stated "I	W99	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BU	LDIN	G		c
		14G255	B. WII	NG _			1/ 2011
	ROVIDER OR SUPPLIER			62	EEET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET OYLETON, IL 62803		
(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
W9999	(Registered Nurse) states the following "When should I con 3. Anytime vital sign 4. Any significant ch 5. When the individ appears to be ill. 6. Anytime someon from the hospital. 9. Anytime you feel individual's situation individual's situation individual's disease 13. Anytime you feel individual is not bein Please Note: Keep calls. It will help with documentation with know what is going contacted on. It will information if the Rion your shift." Review of facility's protocol" (dated Maclearly identify who policy does not identify who will constatus changes prices of that interventions a possible hospitalis state where staff and significant in the results of the staff and state where staff and significant in the results of the staff and significant in	tled, "Contacting RN protocol" (dated March 2007): ttact the RN? as are not within normal limits. annual is not acting as usual, or e is hospitalized or discharged uncomfortable with an or have questions about an or condition. el a medical problem with an	W9	999			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(ULTIF ILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		14G255	B. WI	NG			C 1/2011		
NAME OF PROVIDER OR SUPPLIER TERRA ESTATES (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			•	62	EET ADDRESS, CITY, STATE, ZIP CODE 20 NORTH MAIN STREET OYLETON, IL 62803				
(X4) ID PREFIX TAG	/= .		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		NCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W9999	made by staff and have supported by staff and have supported by staff and have supported by the LPN's Mondon Staff had called Phychanges in R1's Alled Phychanges in R1's Quarterly with Director on 8/10/11 10:51 AM, E2 state by the LPN's Mondon 9:00 PM and on we stated that when the RN consultant in the LPN's are not on asked who staff worther facility, E2 state confirmed that she evidence of DSP or directly regarding R unable to provide worth regards to specificate DSP's, LPN's and F The facility also was facility's system on whenever their was medical status. 5) In review of R1's 8/2/11) their was not by the RN or of the regarding changes. R1's Quarterly Nurse by the E3/LPN for 60 and the staff and the sta	Notes 4/11/11- 8/2/11, there tion that RN had been called in R1's status by LPN, RSD or documentation that nursing visician's office to notify of atus. E2/Residential Service at 9:18 AM and 8/17/11 at d that the facility has coverage ay through Friday 7:00 AM-ekends 7:00 AM-5:00 PM. E2 e LPN's are not at the facility available. E2 confirmed that in call when off duty. When ould call when LPN's are not at at ad RN would be notified. E2 was unable to provide written in LPN staff contacting the RN and the facility's system is in ally who, when and how the RSD would contact the RN. Is unable to provide the who would call the Physician a change in residents Nurse's Notes (4/11/11- owritten documentation made staff reporting to the RN	W9	999					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		RIPLE CONSTRUCTION NG	COMPLETED	
		14G255	B. WIN	NG _			C 1/ 2011
	ROVIDER OR SUPPLIER			(REET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH MAIN STREET HOYLETON, IL 62803		.,
(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
W9999	had reviewed the quas they were done. In review of R1's F7/7/11) there was nevaluated or monitor. In interviews with Z and 8/12/11 at 3:16 assess R1 when shospital, Z3 stated, asked when she wo stated, "With the ardid a physical asses" Once a year with the amonth before the whole record. I revicconsults everything confirmed that she labs, consults, discit they changed, but on the labs, consults, discit they changed, but on the labs, assessments, Z3 stated, asked when she would assessments as a series of the labs, consults everything confirmed that she labs, consults, discit they changed, but on the labs, consults, discit they changed that the RN could massessments, Z3 stated, asked when she with the labs, consults, discit they consult they consult they can be a stated or they can be a	Hospital Discharges (4/15/11- o evidence that the RN had ored R1's medical status. 3/RN on 8/11/11 at 12:06 PM PM, when asked who would be was discharged from the "LPN's will assess." When build review R1's consults, Z3 anual." When asked when she assment of R1, Z3 stated, the annual." Z3 stated, the annual is due, I review the ew all the quarterlies, labs, that's in the record." Z3 did not review quarterlies, harges as they occurred or as once a year at the annual. Z2/Nurse Practitioner on when asked if she would informed of R1's status so take recommendations and	W99	999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDI			0
		14G255	B. WING			1/2011
	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH MAIN STREET HOYLETON, IL 62803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W9999	other special staffin related to R1's med 6) R1's Individual S states the following "Recommendations" "Monitor for cardiac and report to nurse "Due to history of U monitor for symptor Review of R1's ISF specifically identify monitor. The reconspecifically identify respiratory, and uring symptoms that the are to monitor and use to moni	1, the facility did not have any g meetings except the 7/12/11 ical status. ervice Plan (dated 10/6/10) under section titled 3": and respiratory symptoms TI (urinary tract infection), ms of urinary tract infection." of 10/6/10 does not what direct care staff are to nmendations do not what type of cardiac, nary tract infection signs and Direct Support Professional	W9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SURPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		IPLE CONSTRUCTION NG	COMPLE	TED
		14G255	B. WIN	۱G _		08/31	C 1/ 2011
	ROVIDER OR SUPPLIER			6	REET ADDRESS, CITY, STATE, ZIP CODE 620 NORTH MAIN STREET HOYLETON, IL 62803	00,0	
(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
W9999	Review of the ISP recommendations rinterventions for R1 related to the consultonspitalizations from Review of Nursing Consultations (4/11 Discharge Summar (4/15/11-7/22/11) through the Regist recommendations of the R1's change in many make further recommendations of R1's change in many make further recommendations, E2 stassessments, she'll annual and will revisitated that the RN vindividuals and that R1 on 7/12/11. E2 of 2011, the facility did staffing meetings ex R1's medical status other evidence of Z2 of the commendations of Z2 of the R1's medical status other evidence of Z2 of the R1's medical status other evidence of Z2 of R1's medical status of R1 of R	ntake has been poor and staffer to eat." of 7/12/11 does not state any made by the RN of specific 's change in medical status altation of 5/24/11 or the m 4/11/11- 7/7/11. Notes (4/11/11-8/2/11), R1's /11-7/29/11) and Hospital y/ Instructions here is no documentation ered Nurse of any further of interventions made related hedical status. E2/ Residential Service 11/11 at 12:21 PM and when asked the facility's RN/ Registered Nurse for SR1's status so that she ecommendations of ated, "The RN does yearly come in the month before the ew R1's record." E2 further will attend special staffing's for they had a special staffing for confirmed that since April I not have any other special scept the 7/12/11 related to 1. E2 confirmed there was no 23/RN making changes to the specific interventions for R1's	W99	999			