STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145044	A. BUILDING ______ B. WING ______	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-PERU	1301 21ST STREET PERU, IL 61354

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19 to monitor the residents neurological status and it remained within normal limits until the morning she was found unresponsive. We don't routinely do head CT's without indication (signs and symptoms) and since this resident did not have any indication I did not order one. The facility followed the appropriate protocol for post fall resident care."	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1210b)c) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest	F9999		

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F9999	Continued From page 20 practicable physical, mental, and psychological 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. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Requirements are NOT MET as Evidenced by: Based on observation, interview, and record review the facility staff neglected to operationalize their policy on full body (mechanical) lifts and create an environment of safety for one of three residents (R1) in the sample of three. E3,Certified Nurse Aide (CNA) knowingly disregarded facility policy and transferred R1 without using a	F9999		

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F9999	Continued From page 21 mechanical lift. R1 received a fractured femur and subsequent amputation of the leg. The facility staff transferred (R1) utilizing a pivot transfer instead of using a mechanical lift as care planned for one of three residents (R1) in the sample of three. (R1) sustained a fractured leg and subsequent amputation of that leg. Findings include: 1. Admission Data Sheet for R1 documents the date of admission as 10/13/10 with the following diagnoses: Cardiovascular disease, old fracture of left tibia/fibula (lower leg), and Osteoporosis. The care plan for R1 dated 03/01/12 documents the following: "Transfer with assistance of two and full body lift (mechanical lift)." Nurses notes for R1 dated 10/23/12 at 10:55AM and signed by E4, Registered Nurse (RN) document the following: " Upon CNA transferring resident into wheelchair resident complained of left leg pain. Left knee visibly swollen. Doctor notified and resident given Norco as ordered for pain. Order received for resident to be seen in ER (Emergency Room). POA (Power of Attorney) notified." Facility Incident Investigation Report for R1 dated 10/23/12 documents the following: "(E3/CNA) self reported she had done a pivot transfer with (R1) rather than using the required full body (mechanical) lift. Post transfer resident complained of pain in the left knee. (E3/CNA) immediately notified the nurse as well as E2 (DON/Director of Nursing). Both nurses	F9999		

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	145044	A. BUILDING ______ B. WING ______	C 11/30/2012

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F9999	Continued From page 22	F9999		

assessed the knee and noted slight swelling with no discoloration and no loss of movement. (R1's) physician was notified as well as the POA. (R1) was transferred to the ER for evaluation and admitted to (hospital) with a diagnosis of left distal femur (thigh) fracture. (E3/CNA) admitted she did not follow care plan regarding transfer of (R1)."

On 11/21/12 at 2:30PM E1, Administrator stated, "In October (E3/CNA) did not use the lift (mechanical) and did pivot transfer (R1). (R1) has Osteoporosis so when E3 transferred the resident using a pivot transfer it caused the fracture. (E3) received a suspension for this."

On 11/27/12 at 10:15AM E4, RN stated, "(E3) came to me and said she inappropriately transferred (R1) and that the resident's left knee was swollen. I gave (R1) a pain pill and notified the doctor who had us send (R1) to the emergency room. (R1) returned later that day with a cast on that leg due to a fracture."

On 11/27/12 at 10:00AM E3, CNA stated, "I stood and pivoted (R1) from the bed to the wheelchair. I was aware that I was supposed to use a (mechanical lift). (R1) did bear weight during the transfer. (R1) complained of pain in the left knee when I went to put that foot on the wheelchair pedal. I could hear a popping sound when I moved (R1's) foot. It was like a grating sound. I went to the nurse and told her what I did then went to (E2, DON) and also told her. I got a two day suspension for not following the care plan."

Nurses notes for R1 dated 10/23/12 document that R1 was returned to the facility at 1:00PM with a cast from "groin to toes". Nurses notes for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145044	A. BUILDING ______ B. WING ______	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-PERU	**1301 21ST STREET** **PERU, IL 61354**

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F9999	Continued From page 23 11/20/12 at 1:40PM documents the following: "CNA notified nurse of cast assessment that shows medial aspect of left knee cast showing 2cm (centimeter) by 1cm irregular discoloration to cast area. Cast remains hard and dry. Physician notified. POA notified." Same nurses notes document that at 2:45PM R1's physician called back with orders for R1 to be sent to ER for evaluation. Same nurses notes for R1 document that at 6:00PM hospital notified facility that resident was admitted, cast was removed due to pus formation under the cast from an opened wound at the fracture site. Hospital History and Physical Examination for R1 dated 11/20/12 documents the following: "(R1) was brought to the emergency room, the cast was removed and (R1) was found to have about a 2cm hole to skin with a large amount of blood pustular drainage to the distal femur over the fracture site. (R1) continues to have a nonunion at the distal aspect of the tibia as well which was from approximately six years ago. At this point it was recommended the patient be admitted to the hospital on surgical floor and be placed NPO (nothing by mouth) with consent for above the knee amputation on 11/21/12." On 11/27/12 at 9:00AM R1 was lying in the hospital bed. R1 was awake but confused. R1 had received an above the knee amputation of the left leg. A dry dressing was in place covering the amputation site. On 11/27/12 at 10:00AM Z1, R1's surgeon stated, "Moving this resident without using the mechanical lift caused the fracture given the residents severe Osteoporosis. Even though this	F9999		

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F9999		F9999		

Continued From page 24
recent fracture did not help (R1's) situation, I spoke with the family prior to this most recent fracture and recommended amputation because the old fracture of this resident's lower leg had never healed. The family was going to make a decision after the holiday when this most recent fracture occurred. This hastened the family to make a decision and they decided to have the amputation done now."

Facility Resident Handling Policy "No-Lift" dated 02/07/12 and signed by E3, Certified Nurse Aide (CNA) on 11/10/11 documents the following: The Resident Handling Policy exists to ensure a safe working environment. Resident transfer status will be reviewed via care plan time frame and on an as needed basis. This policy will be reviewed and signed by all staff that perform or may perform resident handling. This policy is to be followed at all times."

The care plan for R1 dated 03/01/12 documents the following: "Transfer with assistance of two and full body lift (mechanical lift)." Nurses notes for R1 dated 10/23/12 at 10:55AM and signed by E4, Registered Nurse(RN) document the following:" Upon CNA transferring resident into wheelchair resident complained of left leg pain. Left knee visibly swollen. Doctor notified and resident given Norco as ordered for pain. Order received for resident to be seen in ER (Emergency Room). POA (Power of Attorney) notified."

(B)

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F9999	Continued From page 25	F9999		

LICENSURE VIOLATIONS (continued)
300.610a)
300.1210b)c)
300.1210d)6)
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care
b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive 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.
c) Each direct care-giving staff shall review and be knowledgeable about his or her residents'

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HERITAGE HEALTH-PERU	**1301 21ST STREET PERU, IL 61354**

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F9999	Continued From page 26	F9999		

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:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Requirements are NOT MET as Evidenced by:

Facility staff also failed to provide safety during repositioning for one of three residents (R2) in the sample of three. During repositioning of R2, E5(CNA) pulled on the sheet causing R2 to roll out of bed. E5 returned R2 to bed and failed to notify the nurse of the fall at the time of the occurrence. R2 received nasal fractures and a subdural hematoma (bleeding within the brain). The facility neglected to operationalize their policy on reporting falls for one of three residents (R2) sampled for falls in a total sample of three. E5 CNA knowingly falsified R2's fall from bed for over 24 hours until confronted about R2's bruising. R2 fell from the bed during cares sustaining facial fractures and subdural

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	145044	A. BUILDING ______ B. WING ______	C 11/30/2012

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HERITAGE HEALTH-PERU	1301 21ST STREET PERU, IL 61354

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F9999	Continued From page 27	F9999		

hematoma. E5, CNA neglected to follow the facility policy on reporting falls and moved R2 back to bed without alerting the nurse first.

2. The Admission Face Sheet for R2 documents date of admission as 10/08/05 with the following diagnoses: Cardiovascular Disease, Dementia, Osteoarthritis, and Osteoporosis. The care plan for R2 dated 05/13/12 documents that R2 is to be transferred using a mechanical sit to stand lift and that R2 is a one person assist for bed mobility.

Facility "Fall Assessment,Risk Identification and Management Policy/Post Fall Assessment" dated 03/20/12 documents the following: "After a fall, the resident will not be moved from their position until a licensed nurse determines it is safe to do so."

Facility Resident Handling Policy "No Lift" dated 02/07/12 and signed by E5, CNA documents the following: "Should a resident fall to the floor, the resident will be first assessed by a nurse."

Nurses notes for R2 dated 06/27/12 at 12:30PM document the following: "noticed purple bruising below right eye. CNA states resident pulled on CNA's name tag and bumped nose."

Occurrence Report for R2 dated 06/27/12 documents the following: "CNA came to nurse stating that the resident received a skin tear. Upon entering the room noted a 1cm skin tear to the bridge of the resident's nose. Resident was laying in bed. CNA stated that she was leaning over the resident and the resident grabbed at the CNA's name tag. When the CNA went to pull it

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	145044	A. BUILDING ______ B. WING ______	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-PERU	**1301 21ST STREET PERU, IL 61354**

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F9999	Continued From page 28 back the resident let go and the name tag hit the resident in her nose. After breakfast the resident had a dark purple bruise under the left eye, after lunch the resident was noted to have a dark purple bruise under the right eye and some light purple bruising to the left cheek. Physician and POA (Power of Attorney) notified." Nurses notes for R2 dated 06/28/12 at 9:00AM documents the following: "Midnight CNA (Certified Nurse Aide) reports bruising to right hip. Deep purple bruise on right Iliac Crest (upper hip). Noticed also a faint purple (bruise) to right trochanter (upper thigh), right side of head, an abrasion on second toe of right foot and right knee swelled. Complete head to toe assessment completed. Contacted (Z2, R2's physician) and (R2's) POA. Orders received to send (R2) to hospital for X-ray of knee." Nurses notes for R2 dated 06/29/12 document the following "Late entry for 06/28/12. CNA reports that on 06/27/12 resident rolled out of bed onto floor with no apparent injuries so CNA put resident back to bed. (Z2, R2's Physician) aware that resident rolled out of bed onto floor. Resident's sister also notified." Occurrence Report for R2 dated 06/28/12 and signed by E2, Director of Nursing (DON) documents the following: "On 06/27/12 it was reported that (R2) had cut nose with a CNA's name tag. On 06/28/12 (R2) presented with several more areas of discoloration, two areas on the iliac crest and one on the right trochanter. Resident was lying too close to the edge of the bed. A CNA (E5) entered the room and attempted to pull (R2) back toward the center of	F9999		

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	145044	A. BUILDING ______ B. WING ______	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-PERU	**1301 21ST STREET PERU, IL 61354**

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F9999	Continued From page 29 the bed and the resident rolled out. The CNA (E5) then placed the resident back in the bed without calling a nurse and reported to the nurse only that the resident had cut her face with the CNA's name tag." Incident Report to Illinois Department of Public Health (IDPH) for R2 dated 06/28/12 and signed by E1, Administrator documents the following: "... (R2) is severely impaired and non-interviewable. She requires assistance of one and a sit to stand lift for all transfers. She is dependent on staff for all ADL's (Activities of Daily Living). On 06/28/12 was notified of bruises of unknown origin noted on (R2). A nursing assessment was completed. Bruises were noted on right hip and right knee. An abrasion to right side of head and swelling of right knee was also noted. POA and physician were notified. (R2) was sent to the hospital for an X-ray of right knee returning to the facility with no findings. Upon investigation, (E5/CNA) stated she observed (R2) roll out of bed onto the floor on 06/27/12. (E5) stated she returned (R2) to bed. Per (E5's) signed statement, she did not report the occurrence to the nurse or any other staff. (E5) has been terminated." Statement signed by E5, CNA dated 06/28/12 documents the following: "I went in to get (R2) up. She was close to the edge (of bed). I raised her bed a few inches. I moved the pad. She started to roll and I tried to catch her, but she fell on the floor and rolled over. She landed on her face on the floor. I picked her up and put her to bed. I was trying to wash her up and she tried to pull my name tag and it cut her nose. I reported the cut to the nurse but not the fall."	F9999		

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HERITAGE HEALTH-PERU	1301 21ST STREET PERU, IL 61354

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 30	F9999		

On 11/27/12 at 9:50AM E5, CNA stated, "I was getting (R2) ready to get up. She was close to the edge of the bed so I pulled on the sheet to move her and she rolled off the bed onto the floor. I picked her up and put her back to bed. She had a scratch on her nose. I told the nurse she got that from my name tag."

Facility Neurological assessment Flow Sheet for R2 from the dates of 06/28/12 through 06/29/12 document neurological assessments were done on R2 and all assessments were within normal limits. Nurses notes for R2 for the same time period document no change in condition or level of consciousness.

Nurses notes for R2 dated 06/30/12 at 7:00AM document the following: "CNA called nurse to residents room. Noted resident to be up in chair, leaning to the right. Resident mouth is open and drooping to the right side. Bottom teeth (dentures) had fallen out and resident was drooling. Resident transferred to bed. Apical pulse irregular. Resident noted to use abdominal muscles with breathing. Resident's extremities are flaccid and laying straight out in the bed. No response to verbal or tactile stimuli. Pupils equal and reactive. Discoloration remains to both eyes (dark purple) and left side of face light purple. Notified (Z2, R2's physician) and received orders to transfer to hospital. Ambulance called and resident transferred. POA notified."

Hospital Head CT (Computerized Tomography) for R2 dated 06/30/12 documents a large subdural hematoma (area of bleeding in the brain) with significant mass effect (pressure) upon the right hemisphere (side) causing greater

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145044	A. BUILDING ______ B. WING ______	C 11/30/2012

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HERITAGE HEALTH-PERU	**1301 21ST STREET PERU, IL 61354**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 31	F9999		

than 2cm (centimeters) midline shift of the brain to the left side with impending herniation of the brain.

Hospital CT of facial bones for R2 dated 06/30/12 documents nondisplaced comminuted (spiral) nasal bone fractures.

Nurses notes for R2 dated 07/03/12 at 12:45PM document that R2 was readmitted to the facility from the hospital. R2 had no verbal or tactile response noted. Nurses notes continue to document that R2's POA (Power of Attorney) was contacted in regards to R2's condition and NPO (nothing by mouth) status. POA does not want hospice at this time, declined feeding tube and wants comfort measures only.

Nurses notes for R2 dated 07/03/12 at 8:00PM document the following: "Condition remains poor. Repositioned for comfort." Nurses note for R2 continue to document that R2 was monitored throughout the night.

Nurses notes for R2 dated 07/04/12 at 4:25AM document the following: "CNA reported change in condition Resident stopped breathing. No apical pulse and no blood pressure heard. Pupils dilated. Death verified by two nurses. (Z2,R2's physician) and POA notified of (R2's) death."

On 11/27/12 at 1:30PM E1, Administrator stated, "(E5/CNA) should have told the nurse when (R2) fell to the floor. We did follow up and monitor this resident as the physician ordered. We involved the physician in all aspects of the residents care. We kept in constant contact with (R2's) family. I had to terminate E5. She lied to us about what

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145044	A. BUILDING ______ B. WING ______	C 11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-PERU	1301 21ST STREET PERU, IL 61354

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 32	F9999		

happened and I could not trust her after that."

On 11/27/12 at 6:00PM Z2, R2's physician stated, "I was aware of the fall that occurred when (R2) rolled out of bed. I was involved in the investigation. I gave orders for the facility to sent the resident to the emergency room for X-rays. At that time the residents neurological assessment was within normal limits so a CT of the head was not indicated. The facility continued to monitor the residents neurological status and it remained within normal limits until the morning she was found unresponsive. We don't routinely do head CT's without indication (signs and symptoms) and since this resident did not have any indication I did not order one. The facility followed the appropriate protocol for post fall resident care."

(B)