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| _ IIIInois L                          | Department of Public   | Health   |              |   |        |                  |
|---------------------------------------|--|--|--------------|---|--------|------------------|
|                                       | NT OF DEFICIENCIES<br>NOF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;   | 1            | LE CONSTRUCTION                               |        | SURVEY<br>PLETED |
| ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |  | DENTA TOTALION POMBER.   | A. BUILDING  | S:  | COM    | FLETED           |
|                                       |  | IL6005920  | B. WING      |   | 02/    | 19/2015          |
| NAME OF                               | PROVIDER OR SUPPLIER   | STREET AC  | DRESS, CITY, | STATE, ZIP CODE                               |        |                  |
| HERITA                                | GE HEALTH-EL PASO  | 555 EAS  | CLAY         |   |        |                  |
|                                       | - TEALTH LET AGO   | EL PASO  | , IL 61738   |   |        |                  |
| (X4) ID<br>PREFIX                     |  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION SHOUL           |        | (X5)<br>COMPLETE |
| TAG                                   | REGULATORY OR L  | SC IDENTIFYING INFORMATION)  | TAG          | CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) |        | DATE             |
| S9999                                 | Final Observations   |  | S9999        |   |        |                  |
|                                       | Licensure Violations   | S  |              |   |        |                  |
|                                       | 300.610a)<br>300.1210b)<br>300.3240a)  |  |              |   |        |                  |
|                                       | a) The facility shall I procedures governing facility. The written period formulated by a Committee consisting administrator, the amedical advisory conformed for an and other policies shall comply the written policies the facility and shall   | dvisory physician or the mmittee, and representatives services in the facility. The with the Act and this Part. shall be followed in operating be reviewed at least annually ocumented by written, signed  |              |   |        |                  |
|                                       | b) The facility shall pand services to attain practicable physical, well-being of the reseach resident's complan. Adequate and care and personal caresident to meet the care needs of the resonal care and personal care and personal caresident to meet the care needs of the resonal | eneral Requirements for al Care provide the necessary care nor maintain the highest mental, and psychological ident, in accordance with prehensive resident care properly supervised nursing are shall be provided to each total nursing and personal sident. Restorative measures inimum, the following |              | Attachment A Statement of Licensure Viola     | ations |                  |

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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|---|---|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: | (X3) DATE SURVEY<br>COMPLETED |
|   | IL6005920   | B. WING                                  | 02/19/2015                    |

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

## **HERITAGE HEALTH-EL PASO**

555 EAST CLAY EL PASO. IL 61738

| EL PASO, IL 61738 |  |  |   |  |  |
|-------------------|--|--|---|--|--|
| (X4) ID<br>PREFIX | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL   | ID   | PROVIDER'S PLAN OF CORRECTION   | (X5)   |  |
| TAG               | REGULATORY OR LSC IDENTIFYING INFORMATION)   | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | COMPLET<br>DATE  |  |
| S9999             | Continued From page 1  | S9999  |   |  |  |
|                   | procedures:  | TO THE PROPERTY OF THE PROPERT |   | 10000  |  |
|                   | Section 300.3240 Abuse and Neglect   |  |   | Primaria de la constanta de la |  |
|                   | a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.   | ***************************************  |   |  |  |
|                   | These Regulations were not met as evidenced by:  |  |   | The state of the s |  |
|                   | Based on observation, interview, and record review the facility failed to ensure that nursing call lights were answered in a timely manner for one of 12 residents (R15) reviewed for call lights in a sample of 14 and two residents on the supplemental sample (R20 and R21). This failure resulted in a normally continent resident being incontinent and verbalizing unnecessary embarrassment over incontinence. Findings include: Facility's "Call Light" policy documents, "1. Answer Call light promptly." On 2/19/15 at 11:15 A.M. E1 (Administrator) |  |   |  |  |
|                   | stated, "Prompt means as soon as they can." E1 also stated, "No one should turn a call light off if the resident's need has not been met."  1. R15's Brief Interview for Mental Status (BIMS), dated 12/18/14, notes R15 to be cognitively intact with no memory deficits.  R15's Minimum Data Set (MDS), dated 12/18/14,  |  |   |  |  |
|                   | notes R15 to be always continent of urine and bowel. On 2/17/15 at 2:30 P.M. R15 stated, "The call lights are not answered promptly here. The aides (Certified Nurses Aides/CNA) will take a while to answer the light, or they will cancel the light and  |  |   |  |  |
| 1                 | then forget to come back to help me with going to  |  |   |  |  |

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|---|---|--|---|--|-------------------------------|------------------|
| STATEMENT OF DEFICIENCIES (X1) F AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                  |
|   |   | IL6005920  | B. WING                                 |  | 02/                           | 19/2015          |
| NAME OF   | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY,                            | STATE, ZIP CODE  |                               |                  |
| HERITA  | GE HEALTH-EL PASO   | 555 EAST<br>EL PASO.   | CLAY<br>IL 61738                        |  |                               |                  |
| (X4) ID   | SUMMARY STA   | TEMENT OF DEFICIENCIES   | ID                                      | PROVIDER'S PLAN OF CORRECTION  | )N                            | (X5)             |
| PREFIX<br>TAG   | 1   | MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG                           | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE                          | COMPLETE<br>DATE |
| S9999   | Continued From page   | ge 2   | S9999                                   |  |                               |                  |
|   | and I ended up havieven made a mess never an issue for nowhen I need to go to and so embarrassed will never forget that wait a long time a local leave my call light of the bathroom becauthen not come back On 2/19/15 at 8:45 / stated, (Z1) was on January 27, 2015 who (R15's) call light had and no one had combat after some time the light and R15 sa bathroom. The aided did not return. Z1 in call light again. After other staff members light, but R15 was now minutes of their phoom (R15) told me (R15) hold it and had an accombat after will I."  On 2/19/15 at 12:15 Aide/CNA) stated R15 was toiled "ended up being incombat and usually incombat and usually incombat and supplied the staff was toiled "ended up being incombat and usually incombat and supplied the staff was toiled "ended up being incombat and usually incombat and | A.M., Z1 (R1's relative/POA) the phone with (R15) on hen (R15) mentioned that dibeen on for several minutes he to answer it yet. Z1 stated a staff member answered id R15 needed to go to the exanceled the light and then estructed R15 to turn on the exance in to cancel the call to toileted the entire 51 ne conversation. Z1 stated, ended up not being able to exident. (R15) was upset and (R15) won't forget this and P.M., E6 (Certified Nurses 15's call light was canceled eted. E6 also stated R15 continent." E6 also stated R15 |   |  |                               |                  |

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stated, "I hit my light about ten minutes ago and still don't have help. I really need to go to the bathroom." At this time, R15's call light was not

illuminated outside of R15's bedroom. R15 stated, "My call light isn't on because they came in, turned it off, and left. They have not come

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: | (X3) DATE SURVEY<br>COMPLETED |
|---|--|--|-------------------------------|
|   | IL6005920  | B. WING                                  | 02/19/2015                    |

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE HEALTH-EL PASO

555 EAST CLAY EL PASO, IL 61738

| (X4) ID       | SUMMARY STATEMENT OF DEFICIENCIES   | ID.                 | PROVIDER'S PLAN OF CORRECTION   |                         |
|---------------|---|---------------------|---|-------------------------|
| PREFIX<br>TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLET<br>DATE |
| S9999         | Continued From page 3   | S9999               |   |                         |
|               | back yet to take me to the bathroom and I am scared I am going to have an accident." At 10:22 A.M., E7 (Certified Nurses Aide/CNA) finally entered R15's bedroom to assist R15 to the bathroom.  The facility's log "Nurse Call Executive Information System: Detailed Patient Activity Report" documents R15's call light initially alarmed at 10:08 A.M. on 2/19/15.  On 2/19/15 at 10:22 A.M. when E7 entered R15's room to toilet R15, E7 verified that E7 had canceled R15's call light at 10:10 A.M. and did not toilet R15 at that time.  2. On 2/19/15, at 9:12 A.M., R20 stated earlier this week R20 turned R20's call light on "to be changed" (was incontinent of urine). R20 stated a CNA answered R20's call light, told R20 "someone would be in", turned R20's call light off, and left the room. R20 stated R20 then waited at least an hour and no staff returned, so R20 turned R20's call light on again. R20 stated "I didn't like (waiting). It isn't good to sit in it (urine), I know that."  3. On 2/19/15, at 9:38 A.M., R21 stated R21 has had to wait up to a half an hour for R21's call light to be answered to use the restroom. R21 also stated "Once in awhile they (the staff) turn the call light off and say they'll be back with help, but they get busy or forget and don't come back." |                     |   |                         |

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