STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004253	A. BUILDING: _____ B. WING _____	C 03/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-MENDOTA	1201 FIRST AVENUE MENDOTA, IL 61342

(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) COMPLETE DATE
S 000	Initial Comments Statement of Licensure Violations Facility Reported Incident of 2-24-19/IL109888	S 000		
S9999	Final Observations Statement of Licensure Violations Facility Reported Incident of 2-24-19/IL109888 300.610 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004253	A. BUILDING: _____ B. WING _____	C 03/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-MENDOTA	1201 FIRST AVENUE MENDOTA, IL 61342

(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) COMPLETE DATE
S9999	Continued From page 1	S9999		

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.

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 Regulations were not met as evidenced by:

Based on interview and record review, the facility failed to supervise a confused resident in order to prevent recurrent falls for one of three residents (R1) reviewed for falls in a sample of three. This failure resulted in R1 falling and sustaining a fractured 4th lumbar vertebra.

Findings include:

The facility's Fall Assessment, Risk Identification and Management Policy (revised 3/20/12) documents the following: "It is the policy of this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004253	A. BUILDING: _____ B. WING _____	C 03/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-MENDOTA	1201 FIRST AVENUE MENDOTA, IL 61342

(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) COMPLETE DATE
S9999	Continued From page 2	S9999		

facility to assess each resident's fall risk on admission. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk. Factors related to the risk will be addressed and care planned," and "Interventions to manage falls: A. Interventions will be based on the resident assessment and the circumstances surrounding the risk for injury or actual injury or fall. Some examples may be: 2. Falls related to confusion."

R1's face sheet documents R1 was admitted to the facility on 2/23/19 with Diagnoses of Aftercare following joint replacement surgery and presence of left artificial knee joint.

R1's Admission Nursing Assessment and Care Plan dated 2/23/19 documents the following: memory problem with recall after five minutes, confusion, requires assistance of two staff to walk, assistive devices of gait belt and walker, two assist with all transfers, and make sure call light is always within reach.

R1's Fall Scale dated 2/23/19 documents R1 is at high risk for falling and that R1 "Overestimates or forgets limits" of their abilities to ambulate safely.

R1's Resident Occurrence Reports document R1 fell on 2/23/19 at 8:40pm and 2/24/19 at 7:40pm. The report dated 2/23/19 documents R1 was alone in her room, stood up from the recliner in her room when she thought she heard her daughter's voice, used the walker to walk out to the hallway and fell, hitting her head and sustaining a "bump to back/right side of head." The report documents the intervention put into place following this fall was "Slipper socks at HS (hour of sleep) and while in bed."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004253	A. BUILDING: _____ B. WING _____	C 03/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-MENDOTA	1201 FIRST AVENUE MENDOTA, IL 61342

(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) COMPLETE DATE
S9999	Continued From page 3	S9999		

On 3/1/19 at 9:10am V9, Licensed Practical Nurse (LPN) stated on 2/23/19, R1 self transferred out of the recliner and used the walker to walk out into the hall (where R1 fell), but forgot to call for assistance. V9 stated R1 couldn't remember where she was, and the call light was still in reach on R1's recliner.

On 3/1/19 at 10:10am, V11, Certified Nursing Assistant (CNA), stated she cared for R1 the evening of 2/23/19. V11 stated R1 was alone in her room, got herself up out of the recliner and walked out into the hall, and "(R1) did not turn on the call light, (R1) forgot to. (R1's) confusion seemed to get worse as the evening got later."

R1's Resident Occurrence Report dated 2/24/19 documents R1 was again alone in her room, stood up from her recliner chair in her room, walked to the doorway of her room (without her walker) where she fell and landed on her back. The report documents that the call light was in reach but had not been used. R1's Progress Notes dated 2/24/19 at 9:35pm document R1 complained of right/mid back pain and was transferred to the local Emergency Department. R1's Progress notes dated 2/25/19 document R1 was admitted to the hospital with a "closed fracture 4th (fourth) lumbar vertebrae."

On 3/1/19 at 9:10am V9, LPN, stated on 2/24/19 R1 had transferred out of the recliner and was lying on the floor in the doorway of her room. V9 stated R1 had forgotten to use the call light to call for help and had also forgotten to use the walker.

On 3/1/19 at 10:30am, V12. CNA, stated on 2/24/19 she walked past R1's room, saw R1 sitting in her recliner with her feet raised on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004253	A. BUILDING: _____ B. WING _____	C 03/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-MENDOTA	1201 FIRST AVENUE MENDOTA, IL 61342

(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) COMPLETE DATE
S9999	Continued From page 4	S9999		

leg/foot rest, with call light in reach on the recliner. V12 stated when she came back down the hall about five minutes later, she saw R1 on the floor in the doorway of her room. V12 stated after R1's fall, the foot/leg rest of the recliner was still raised and the call light was still on the recliner.

On 3/1/19 at 9:20am, V10, LPN who completed the Admission Nursing Assessment and Care Plan dated 2/23/19, stated R1 could not remember where (R1) was and could not recall events R1 relayed to V10 five minutes earlier. V10 confirmed she documented R1's Fall/Safety Care Plan only as "Make sure my call light is always within my reach." V10 stated the fall prevention/personal safety teaching she provided to R1 included only using the call light for assistance, and using the walker with staff assistance to walk.

R1's current fall care plan documents the following interventions for R1: "Make sure my call light is always within my reach; assist me to keep non-skid footwear on at all times while I am up; 2/23/19 (following the first fall on 2/23/19) Slipper socks while in bed." R1's care plan also documents "I need two staff assistance to walk," and "I require two assist with all transfers."

On 2/28/19 at 2:10pm, V3, Care Plan Coordinator, reviewed R1's care plan and stated R1's mental status (confusion, memory problem after five minutes, overestimating or forgetting limits) is not addressed in R1's plan of care, but should have been considered when developing fall interventions.

R1's X-ray of the lumbar spine dated 2/24/19 documents "Contour irregularity of the superior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004253	A. BUILDING: _____ B. WING _____	C 03/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-MENDOTA	1201 FIRST AVENUE MENDOTA, IL 61342

(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) COMPLETE DATE
S9999	Continued From page 5 endplate of L4 as well as anterior cortex suggesting acute compression fracture. 10-15% loss vertebral body height." R1's Emergency Department Provider Notes dated 2/24/19 document "Closed fracture of fourth lumbar vertebra, unspecified fracture morphology, initial encounter." (B)	S9999		