STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008510	A. BUILDING: _____ B. WING _____	C 02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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 Facility Reported Incident of 1-20-21/IL130574 Complaint Investigation 2160684/IL130628	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.1220b)3) 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. 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	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
	IL6008510	A. BUILDING: _____ B. WING _____	C 02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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 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 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008510	A. BUILDING: _____ B. WING _____	C 02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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 indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements were not met as evidenced by: Failures identified required more than one deficient practice statement. A. Based on observation, interview and record review, the facility failed to safely transfer a resident resulting in the resident sliding toward the floor from the mechanical lift sling and being assisted to the floor by staff. The facility also failed to investigate falls to determine the root cause, failed to implement post fall interventions after multiple falls for three of three residents (R4, R5, R6) reviewed for falls in the sample of six. These failures resulted in R4's right arm humeral neck fracture with pain and R6's left hip fracture. B. Based on interview and record review, the facility failed to complete an investigation to determine a root cause and implement interventions for one of three residents (R1) reviewed for eating who experienced a choking incident in the sample of six. Findings include: The facility's Fall Assessment and Management Policy dated April 2019 documents the facility is to assess fall risk on admission, quarterly and with each fall to 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. The interdisciplinary care plan will be person centered to reflect the specific needs and risk factors of the resident. Interventions will	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008510	A. BUILDING: _____ B. WING _____	C 02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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 be based on the fall risk assessment and the circumstances surrounding the risk for injury or actual injury or fall. A licensed nurse will immediately assess the resident and parameters after a fall including a description of how the resident was observed with circumstances surrounding the fall, unusual signs or symptoms, environmental factors (wet floor, uneven surfaces) and care plans will be updated. A.1. R4's Medical Diagnosis List dated 1/29/2021 documents R4's Diagnoses including Unspecified Psychosis, Anxiety, Delusional Disorder, History of Falling and Weakness. R4's Report to the State Survey Agency dated 1/22/2021 documents on this date at 7:00pm, V15 (Certified Nursing Assistant/CNA) was using the stand mechanical lift to transfer R4 from R4's wheelchair to R4's bed. R4 "let go" of the handles on the lift and dropped R4's arms. The lift sling began to slide up R4's back. V15 stopped the motion of the lift and balanced R4 on V15's knee and yelled for assistance. V16 (Licensed Practical Nurse/LPN) assisted V15 to "lower" R4 to the floor. This Report documents R4 did not have complaints at the time of the incident. There is no documentation that R4's range of motion was assessed after R4's fall. On 1/23/2021 and 1/24/2021, R4 began to complain of "general aches and pains" on both days. On 1/25/2021 R4 complained of right arm and shoulder pain while working with therapy. On 1/26/2021 an X-ray was completed with results documented as a humeral neck fracture of indeterminate age. R4's Physical Therapy (PT) Evaluation & Plan of Treatment notes document R4 had impaired range of motion due to right shoulder and right arm pain. These notes document R4's pain is	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008510	A. BUILDING: _____ B. WING _____	C 02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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		

constant to the right shoulder and has bruising. R4 is guarding the right shoulder and unable to stabilize a sitting balance with the right upper extremity.

On 2/2/2021 at 4:20pm, V12 and V13 (Certified Nursing Assistants/CNAs) provided hygiene care to R4. R4 was wincing during assistance with bed mobility due to pain of the right shoulder per R4's statement. V12 stated R4 broke R4's right arm when R4 fell (on 1/22/2021).

On 2/4/2021 at 11:00am, V20 (Physical Therapist/PT) stated V20 noted R4 guarding R4's right arm/shoulder, with extensive pain and bruising to the right upper arm on 1/25/2021 when V20 completed a therapy evaluation. V20 stated V21 (CNA) reported to V20 that day that R4 had been having the right arm pain.

On 2/4/2021 at 12:00pm, V21 (CNA) stated V21 assisted R4 on 1/23/2021. V21 stated R4 was "screaming" because R4 was having right arm pain. V21 stated V21 reported R4 was "screaming with right arm pain" to V22 (Registered Nurse/RN). V21 stated V22 stated V22 would give R4 some pain reliever and if R4 was in that much pain V21 would have to get something stronger for pain relief. V21 stated she also reported R4 was having the right arm pain, guarding of the right arm and a bruise on the right arm to V20 (PT).

On 2/3/2021 at 3:40pm, V2 (Director of Nursing/DON) stated V2 completed the investigation for when R4 was lowered to the ground after beginning to fall/slide out of the mechanical lift sling. V2 stated V15 (CNA) was transferring R4 by V15's self when R4 let go and began to slide/fall toward the floor. V2 stated R4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008510	A. BUILDING: _____ B. WING _____	C 02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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	S9999		

was weak from being sick with R4's recent COVID (human coronavirus) infection. V2 stated R4's right arm fracture probably happened when R4's arm was pushed up by the sling of the lift as R4 slid/fell toward the floor. V2 stated V16 (LPN) reported V16 had told V15 (CNA) to use the "full mechanical lift" on R4 because R4 was so weak from being so sick. V2 stated R4 had just transferred off the COVID positive unit after 10-12 days of being sick. V2 stated an employee (such as V15) would/should know when a resident is weaker. V2 stated the root cause of R4's fall on 1/22/2021 was "weakness and not using the (full mechanical) lift" as directed. V2 stated V15 should have followed the nurse's instructions and transferred R4 with the full mechanical lift.

On 2/3/2021 at 4:05pm, V14 (Restorative Nurse) stated V14 printed R4's X-ray from the computer. V14 stated the X-ray company calls the facility with results in addition to faxing the report to the facility.

R4's Occurrence Report dated 1/31/2021 documents R4 fell on 1/31/2021 at 8:15am. This report documents R4 was "lowered to the floor" when R4 yelled "help!" as R4 was "sliding out of wheelchair and assisted to the floor." There is no documentation of an investigation for this fall. There is no documentation of the root cause or post fall interventions implemented for this fall.

On 2/3/2021 at 3:40pm, V2 (DON) stated the facility does not complete a "full investigation" for falls/incidents "unless the incident is a reportable (to the State Survey Agency)." V2 stated if "the fall (report) makes sense, then we accept as is." V2 stated the floor nurses are to notify the resident's physician and family, investigate the fall and determine the root cause. V2 stated the floor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008510	A. BUILDING: _____ B. WING _____	C 02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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 6 nurses are also responsible for implementing post fall interventions and updating the resident's care plans after a fall. A.2. R5's Face Sheet dated 3/3/2021 documents diagnoses including Fracture of Nasal Bones (12/1/2020), Restlessness and Agitation, Anxiety, Delusional Disorders, Muscle Weakness, Dementia with Behaviors and COVID 19 positive. R5's Progress Notes dated 12/1/2020 at 8:15am documents R5's nose was swollen, slightly bruised and scratched. R5 complained of generalized pain and was sent to the emergency room for evaluation due to fall with head injury. R5 was newly diagnosed with Fracture of Nasal Bones on 12/1/20. R5's Occurrence Report dated 12/1/2020 at 7:40am documents "a staff member" from R5's unit came up to "east side" and notified "staff" R5 was found on the floor. R5 was laying on R5's right side and had an "abrasion" on the center side of R5's nose. There is no documentation of name or witness statement of the "staff" who reported the fall. This report documents R5 is not independent for toileting. "Care Prior to fall" documents N/A (not applicable) for when R5 was last visually observed, toileted, given fluids, repositioned or medicated for pain or anxiety. Conclusion: R5 was incontinent of bowel and "was trying to get away from the mess in (R5's) bed." R5 was sitting at the end of R5's bed and fell forward landing on R5's right side. This report documents the root cause was R5 had been incontinent, although there is no documentation of when R5 was last toileted or observed. There is no identified post fall intervention for this fall. This report documents R5 was sent to the emergency room for evaluation after	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008510	A. BUILDING: _____ B. WING _____	C 02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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 7	S9999		

"assessment" but does not describe what assessment revealed.

R5's Progress Notes dated 12/1/2020 at 11:48am document the State Survey Agency was "faxed to update about R5's fracture and V1 (Administrator) and V2 (DON) were notified.

R5's Occurrence Report documents R5 was found on the floor on 12/20/2020 at 8:45am. This report documents R5 is "always wanting to lie down" and has been "extra tired" since R5 had COVID infection. R5 stated, "I (R5) just want to lay down." This report documents R5 was found on the floor by V11 (CNA) but does not document a witness statement from V11. This report documents the root cause "due to resident action or internal risk factors," but no specific reason/root cause. There are no documented post fall interventions for this fall.

R5's Occurrence Report documents R5 was found on the floor on 1/29/2021 at 2:25pm. R5 was noted to have had a loose stool at the time of the fall. There is no documentation of an investigation as to the conclusion or root cause of this fall. There is no documentation of post fall interventions implemented after this fall.

R5's Occurrence Report documents R5 was found on the floor next to the side of the bed on 1/29/2021 at 3:55pm and that R5 has had increased weakness since R5's diagnosis of COVID. This report documents R5 "wanted to get out of bed." There is no documentation as to a conclusion or root cause of this fall. There is no documentation of post fall interventions implemented after this fall.

On 2/3/2021 at 3:40pm, V2 (DON) stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008510	A. BUILDING: _____ B. WING _____	C 02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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 8	S9999		

facility does not complete a "full investigation" for falls/incidents "unless the incident is a reportable (to the State Survey Agency)." V2 stated the floor nurses are to notify the resident's physician and family, investigate the fall and determine the root cause. V2 stated the floor nurses are also responsible for implementing post fall interventions and updating the resident's care plans after a fall.

A.3. R6's Face Sheet dated 2/3/2021 documents R6 admitted to the facility on 7/29/2020 with diagnoses including History of Falls, Muscle Weakness, Difficulty in Walking, Edema, Vitamin D Deficiency, Dizziness and Giddiness, Traumatic Subarachnoid Hemorrhage, Multiple Fractures of Left side of Ribs, Dementia and COVID 19. This sheet documents R6 was diagnosed with a Fracture of the Left Femur on 1/29/2021.

R6's Occurrence Report documents R6 had a fall on 1/11/2021 at 6:00am. This report documents R6 was attempting to sit on the toilet and missed, sliding to the floor. This report does not document which staff member found R6. There is no documentation as to R6's care and/or when R6 was last observed prior to the fall. There is no documentation as to what footwear R6 was wearing or environmental conditions at the time of the fall. There is no root cause identified for the fall.

R6's Occurrence Report documents R6 was found sitting on the floor with R6's back against chair with legs extended in from of R6 on 1/13/2021 at 10:07am. R6 was noted to have a skin tear to the left elbow and bruise to the left lower back from this fall. There is no documentation of investigation as to R6's care and/or when R6 was last observed prior to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008510	A. BUILDING: _____ B. WING _____	C 02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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 9 fall. There is no documentation as to what footwear R6 was wearing or environmental conditions at the time of the fall. There is no root cause identified for the fall. This report does not document post fall interventions to prevent future falls. R6's Occurrence Report documents R6 was found on the floor lying on R6's right side in front of R6's room on 1/21/2021 at 6:30pm. This report documents R6 reported trying to get up and R6 fell. R6 complained of left hip pain during the post fall assessment. There is no documentation R6's environment/floor was assessed in the report. This report does not document a conclusion, root cause or that post fall interventions were implemented to prevent future falls from occurring. R6's Report to the (State Survey Agency) dated 1/21/2021 documents R6 was found on the floor and complained of left hip pain. R6 does not remember to use R6's call light. This report documents an hour after the fall, R6 complained of left hip pain and R6 was sent to the emergency room. R6's X-ray performed at the emergency room revealed a left hip fracture and R6 was admitted to the hospital. R6's Care Plan will be re-evaluated upon return from the hospital and care plan will be adjusted to meet R6's needs. R6's Census dated 1/29/2021 documents R6 re-admitted to the facility from the hospital. R6's Care Plans dated 2/1/2021 do not document post fall interventions from R6's fall resulting in left hip fracture on 1/21/2021. B. The facility's Adverse Event Policy dated 11/1/2017 documents the facility's adverse event monitoring will include identification, reporting,	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008510	A. BUILDING: _____ B. WING _____	C 02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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 10	S9999		

tracking, investigating, analyzing and using the data and information related to adverse events in the facility including developing activities to prevent adverse events. The facility must take and implement actions aimed at performance improvement.

R1's Minimum Data Set (MDS) dated 1/6/2021 documents R1 is cognitively intact.

R1's Occurrence Report dated 1/20/2021 documents R1 was eating in R1's room. V3 (CNA) responded to R1's call light and found R1 "slumped in chair and cyanotic." V3 noted R1's food tray in front of R1 and performed the Heimlich Maneuver on R1. "After a couple of thrusts, (R1) coughed up a piece of meat." R1's color returned immediately and R1 began talking. There is no documentation of an interview with R1. There is no documentation of a root cause of the choking incident for R1. There are no evaluations documented from V9 (Dietary Manager), V10 (Registered Dietician/RD) or V11 (Speech Therapist).

R1's Choking Investigation dated 1/25/2021 document R1 expelled a piece of meat that was approximately "the size of a quarter." This investigation does not contain a statement from R1 as to why R1 felt like R1 choked. There is no documentation of evaluation of the meat product that had been served, interviews with additional resident's related to the "beef stew" that day, nor any evaluations by speech therapy or a Registered Dietician regarding the choking incident.

On 2/1/2021 at 12:07pm, R1 stated R1 was eating lunch a couple weeks ago and there was "beef stew." R1 stated R1 typically does not eat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008510	A. BUILDING: _____ B. WING _____	C 02/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-NORMAL	509 NORTH ADELAIDE NORMAL, IL 61761

(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 11 much meat, but thought it looked good and took a piece to try it. R1 stated, "It was too big; I should have cut it smaller first," and R1 choked. R1 said it got stuck in R1' s throat and R1 pushed the call light and tried calling out for help but was unable to do so. R1 stated staff responded fast and "Thank God, I thought I was a goner." R1 stated R1 has had no problems with eating, swallowing or symptoms of any problems in the past. R1 stated the meat in the beef stew was just "too big." R1's Care Plans dated 1/26/2021 do not document updated interventions related to R1's choking incident on 1/20/2021. (A)	S9999		