Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ COMPLETED. B. WING IL6000756 06/27/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **873 GROVE STREET** HERITAGE HEALTH-JACKSONVILLE JACKSONVILLE, IL 62650 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S 000 Initial Comments S 000 Annual Health Statement of licensure violations S9999 Final Observations S9999 300.1210b) 300.1210d)5) 300.3240a) 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. Restorative measures shall include, at a minimum, the following procedures: 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who Attachment A enters the facility without pressure sores does not develop pressure sores unless the individual's Statement of Licensure Violations clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

07/19/19

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6000756	B. WING		06/2	7/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 873 GROVE STREET JACKSONVILLE, IL 62650						
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	N SHOULD BE COMPLETE EAPPROPRIATE DATE	
\$9999	documents, Brief Ir (BIMS) score of 14 The MDS further do 3/3 needs extensive Daily Living (ADLs) R39's Braden scale Braden Score is 12 R39's Ulcer Care Produments R39 de tissue injury (DTI) of measurements of 4 Treatment orders at (High Absorbency For Color black, Keeprep every day. On 6/26/19 R39's Uplan documents, where the color black is present, color of word R39's Care Plan documents R35.9 X 5.9 cm with sepresent, color of word R39's Care Plan documents Pocus: to need for assist we incontinence and discusses limited rangemovement to bilate	nterview for Mental Status, indicating cognitively intact. Documents, Functional Status e assist of 2 for Activities of dated 6/20/19 documents (High Risk). Plan-Treatment Plan veloped an in-house deep discovered on 6/14/19 with X 4.5 centimeters (cm). The Calcium Alginate, ABD, Pad) and kling. Ulcer Care Plan-Treatment ound measurements 3.7 X 3.7 ap heel off loaded, use skin of the Care Plan-Treatment are perosanguinous drainage, odor ound is black/yellow.	S9999			
	foul odor to left out dark red drainage v cleansed area with	s, dated 6/24/19, documents, er heel. Optifoam dressing had when removed. V9, LPN, wound wash, area black in dges. Nurses notes dated				

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