STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6010128	A. BUILDING: _____ B. WING _____	C 01/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-MOUNT ZION	1225 WOODLAND DRIVE MOUNT ZION, IL 62549

(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 December 29, 2021 IL142179	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 d)6) 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. 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. These requirements are not met as evidenced by: Based on record review and interview, the facility failed to monitor a resident using a laptop cushion device while being propelled by staff, which	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resulted in a fall with minor injury for one (R3) out of three residents reviewed for falls. Findings include: R3's undated Face Sheet documents an admission date of 12/5/19, and medical diagnoses of Muscle Weakness, Unsteady on Feet, Abnormalities of Gait and Mobility, Left Hand Contracture, History of Falling, and Dementia Without Behavioral Disturbances. Minimum Data Set (MDS), dated 11/5/21, documents R3's cognitive decision making skills as moderately impaired. This same MDS documents R3 as requiring one person extensive assistance for bed mobility, dressing, eating, toileting and personal hygiene and two person extensive assistance required for transfers. R3's Fall Scale Assessment, dated 12/19/21, documents a fall score of 60, indicating R3 is a high fall risk. R3's Physician Order Sheet (POS), dated January 1-31, 2022, documents a Physician order initiated 3/29/21 for "may have (laptop cushion) while in wheelchair for safety, release at least every two hours and as needed for muscle weakness and unsteadiness and impulsiveness with safety". R3's Contracture Risk Evaluation, dated 11/10/21, documents R3 as having "moderate to severe hand contractures due to previous Cerebral Vascular Accident (CVA)". R3's Care Plan intervention, dated 3/25/21, instructs staff to "provide with correct positioning	S9999		

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S9999	Continued From page 2 with proper body alignment while restrained". R3's Nurse Progress Note, dated 12/19/21 at 12:18 PM, documents "(R3) had a fall at 11:45 am. Initial assessment (R3) is nonresponsive to verbal or physical stimuli. Moderate amount of blood noted to right side of forehead. Pressure applied with gauze. (R3) starts to yell that (R3) is in pain. (R3) is more verbal a this time, but does not follow commands & will not open her eyes." R3's Hospital Record, dated 12/19/21, documents the reason for visit as "fall and head laceration". This same record documents R3's Right Forehead laceration was treated with tissue adhesive and R3 was returned to facility on 12/19/21 without being admitted to the hospital. On 1/7/22 at 12:15 PM, V33 Certified Nurse Aide (CNA) stated, "I (V33) was pushing (R3) in (R3) wheelchair down the hall on the way to the dining room for lunch. I (V33) saw (R3) leaning forward. (V33) couldn't get around to the front of (R3) wheelchair fast enough to push (R3) back. (V33) didn't try to stop the wheelchair or pull (R3) back into the wheelchair from behind. (R3) leans forward like that all the time. (R3) always was leaning over that (laptop cushion)." On 1/18/22 at 3:00 PM, V2, Director of Nursing, stated V33, Certified Nurse Aide (CNA), was pushing R3 down the hall en route to lunch. "(R3) was leaning forward in (R3's) wheelchair. (R3) leaned forward a lot. (V33) should have gently reached for (R3) from behind and pulled (R3) back to prevent the fall. If (V33) were paying attention, (R3) probably wouldn't have fallen. (V33) should have made sure (R3) (laptop cushion) was in the proper place and obviously (V33) didn't."	S9999		

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S9999	Continued From page 3 On 1/18/22 at 3:10 PM, V43, Dietary Aide, stated, "(V43) witnessed (R3) fall. (R3) was leaning really far forward and (R3) (laptop cushion) was only half way on. It was so loose, (V43) am surprised (R3) didn't fall before (R3) did. The Certified Nurse Aide (CNA), should have been paying attention. (V43) don't think (V33) made (R3) fall on purpose but if (V33) would have been paying attention to (R3) (laptop cushion) (R3) might not have fallen at all." (B)	S9999		