STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to timely report an injury of unknown origin to the physician and resident representative. The facility also failed to report changes in medication orders to the resident representative for two (R1, R2) of six residents reviewed for changes in condition in the sample list of 12. Findings include: 1.) R1's Minimum Data Set (MDS) dated [DATE] documents R1 has moderate cognitive impairment. R1's Nursing Note dated 8/12/2024 at 9:58 AM documents new orders were received to stop Plavix. There is no documentation in R1's medical record that this new order was reported to V27 (R1's Family). On 3/19/25 at 10:42 AM V3 (Assistant Director of Nursing/ADON) stated V3 attempted to contact V27 the day R1's Plavix was discontinued, but V3 forgot to document that V3 left a message for V27. V3 reviewed R1's nursing notes and confirmed there was no documentation that V27 was notified of Plavix being discontinued. The facility's Guidelines for Physician Notification of Change in Resident Condition policy dated April 2019 documents resident's representatives, as appropriate, should be notified when there is a change in treatment such as discontinuing a form of treatment. 2.) On 3/17/25 at 11:29 AM V25 (R2's Family) stated the facility contacted V25 on the morning of 3/10/25 to report that R2 had a small bruise. V25 stated R2 was taken to the hospital by family on 3/10/25 and the emergency room physician thought the bruise looked to be five to seven days old. R2's MDS dated [DATE] documents R2 has severe cognitive impairment. R2's Nursing Note dated 3/7/2025 at 10:12 PM documents R2 had bruising on right side near breast that wrapped around R2's side. There is no documentation that this was reported to R2's family or physician until 3/10/25. R2's Nursing Note dated 3/10/2025 at 10:36 AM documents R2's bruise measured 9.5 centimeters (cm) by 26 cm. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25 at 3:35 PM V2 (Director of Nursing/DON) stated R2's bruise was reported to nurse management on 3/10/25 and the bruise was purple, blue, and yellow in color. V2 confirmed yellow bruising would indicate the bruise was aging and not fresh. On 3/17/25 at 4:07 PM V3 (ADON) stated V3 found out about R2's bruise on 3/10/25. This bruise was found on the evening of 3/7/25 and reported to V9 (Licensed Practical Nurse/LPN). V3 stated V3 did not report R2's bruise to nurse management and V3 should have notified R2's family and physician the day the bruise was found. V3 confirmed R2's bruise was considered an injury of unknown origin. On 318/25 at 4:45 PM V9 (LPN) stated on the evening of 3/7/25 V16 and V19 (Certified Nursing Assistants/CNAs) reported R2's bruise. V9 stated the bruise was purple and near R2's ribs and breast, R2 and the CNAs were not sure what caused the bruise. V9 stated V9 thought it might be caused from the stand lift. V9 stated V9 charted about the bruise but did not report R2's bruising to anyone. V9 stated V9 had not had any training on identifying and reporting injuries of unknown origin. The facility's Abuse Prohibition policy dated 3/15/18 documents the charge nurse will report injuries of unknown origin to the resident's physician and family.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to report allegations of abuse and timely report an injury of unknown origin to the facility's administrator and the state surveying agency for three (R1, R2, R6) of eight residents reviewed for abuse in the sample list of 12. Findings include: The facility's Abuse Prohibition policy dated 3/15/18 documents allegations of abuse must be immediately reported to the facility's administrator and the administrator will provide an initial notice of the allegation to the (state surveying agency) immediately after the allegation is known. This policy documents injuries of unknown origin, including significant bruises must be immediately reported to the charge nurse, Director of Nursing (DON) and Administrator. The charge nurse will document the nature of the injury in the resident's medical record, complete an incident report describing the injury and the circumstances of the injury, and notify the physician and resident's representative. Injuries of unknown origin will be reported to (state surveying agency) within 24 hours. The facility's Abuse Tracking Log with last recorded entry as 5/5/24 does not document any allegations of abuse involving R1, R2, or R6. 1.) On 3/17/25 at 11:29 AM V25 (R2's Family) stated the facility contacted V25 on the morning of 3/10/25 to report that R2 had a small bruise. V25 stated R2 was taken to the hospital by family on 3/10/25 and the emergency room physician thought the bruise looked to be five to seven days old. V25 stated V25 was given conflicting stories from the facility as to how the bruise occurred and V25 was told it was caused by a gait belt or a full mechanical lift. V26 (R2's Family) stated R2 often complained of unidentified staff squeezing R2 during cares, which has been reported to management and administration. R2's Minimum Data Set (MDS) dated [DATE] documents R2 has severe cognitive impairment, requires substantial/maximal assistance of staff for toileting and bed mobility, and is dependent on s staff for transfers. R2's active Care Plan documents R2 admitted to the facility on [DATE]. This Care Plan documents R2 has delirium or acute delusional episodes, makes untrue statements, and believes things have actually occurred despite reassurance from staff. This Care Plan does not identify what specific accusations or false statements R2 makes. R2's March 2025 Medication Administration Record documents R2 receives Eliquis (blood thinner) 5 milligrams by mouth twice daily. R2's Nursing Note dated 3/7/2025 at 10:12 PM documents R2 had bruising on right side near breast that wrapped around R2's side. This note documents it appeared to be from the mechanical sit to stand lift sling. There is no documentation that this was reported to V2 (DON) and V1 (Administrator). R2's Nursing Note dated 3/10/2025 at 10:36 AM documents bruise under right arm measured 9.5 centimeters (cm) by 26 cm appears to be from sit to stand lift sling as bruise is same length as sling. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Serious Injury Incident and Communicable Disease Report dated 3/11/25 documents the initial report of R2's bruise of unknown origin was submitted to (state surveying agency) on 3/11/25 at 1:42 PM, four days after the injury was initially found. On 3/17/25 at 1:17 PM V13 (Registered Nurse) stated within the last year R2 voiced complaints during night shift that a pregnant woman would come into R2's room at night and abuse R2. V8 (Certified Nursing Assistant/CNA) was pregnant at that time but did not work on R2's hallway. V8 was no longer allowed to take care of R2 after that. V13 stated V2 (DON) was aware of R2's accusations, interviewed staff and implemented using two staff for R2's cares. On 3/17/25 at 3:35 PM V2 (DON) stated staff have been using two people when providing R2's cares due to R2's history of making false statements. V2 stated R2 would say men were going in R2's room, but we had no men on staff. V2 stated R2 would speak in Spanish to R2's family saying unidentified staff were rough with R2, and both things were reported to V1 (Administrator). V2 stated R2's bruise was reported to nurse management on 3/10/25 and the bruise was purple, blue, and yellow in color. V2 confirmed yellow bruising would indicate the bruise was aging and not fresh. V2 stated V9 (Licensed Practical Nurse/LPN) documented in R2's nursing notes that the bruise was found on 3/7/25 and V9 did not report this to anyone. On 3/17/25 at 4:07 PM V3 (Assistant DON) stated V3 did not realize R2's bruise was considered an injury of unknown origin until after V18 (Corporate Senior [NAME] President of Clinical Operations) was notified, and then the injury was reported to (state surveying agency) on 3/11/25. On 3/18/25 at 8:54 AM V22 (CNA) stated R2 has made allegations since June 2024 that men would come into R2's room and rape R2. V22 stated the nurses were aware, but V22 never reported this to V1 or V2. V22 stated the facility had one male CNA at that time who never took care of R2. On 3/18/25 at 9:13 AM V8 (CNA) stated V8 was not allowed to take care of R2 after R2 accused V8 of pinching R2 sometime in August 2024. V8 stated R2 also made allegations of rape during the night shift and in the hallways, and men weren't allowed to care for R2. V8 stated V1 and V2 were aware because they asked me questions about R2's rape statements. On 318/25 at 4:45 PM V9 (LPN) stated on the evening of 3/7/25 V16 and V19 (CNAs) reported R2's bruise. V9 stated the bruise was purple and near R2's ribs and breast, R2 and the CNAs were not sure what caused the bruise. V9 stated V9 thought it might be caused from the stand lift. V9 stated V9 charted about the bruise but did not notify management. V9 stated V9 had not had any training on identifying and reporting injuries of unknown origin. On 3/18/25 at 1:50 PM V1 (Administrator) confirmed the facility's abuse log did not include any abuse allegations involving R2 between January 2024 and March 2025. V1 stated V1 was not aware of R2's allegations of men going into R2's room, rape, or that staff are rough and pinching R2. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.) On 3/17/25 at 12:40 PM V28 (R1's Family) stated on 2/22/25 V28 called the facility and asked for R1's television (TV) channel to be changed. V28 stated V28 was on the phone and overhead a nurse come into R1's room, was snarky and yelled Ok (R1), I gotta change this TV because (V28) wants me to. V28 stated V28 called the facility and spoke to V13 (Registered Nurse) who confirmed V13 was the person in R1's room who changed R1's TV channel while V28 was on the phone with R1. V28 stated V28 reported this to V1 (Administrator) and V18 (Corporate Senior [NAME] President of Clinical Operations). R1's MDS dated [DATE] documents R1 has moderate cognitive impairment. On 3/17/25 at 1:17 PM V13 stated V28 called the facility and asked for R1's television channel to be changed. V13 stated V13 went to R1's room and changed the TV channel and R1 was on the phone at that time. V13 stated V13 might have been loud when talking to R1 but denied yelling at R1. V28 called back and insinuated V13 was being rude to R1 and V13 reported this to V2 (DON). On 3/17/25 at 2:43 PM V18 stated on 3/10/25 V28 contacted V18 and said that V28 had asked V13 to change R1's television channel and V28 asked V13 why V13 was rude and yelled at R1. V18 stated V18 spoke with V1 and V2, who had already addressed V28's concerns. On 3/17/25 at 3:35 PM V2 (DON) stated on the weekend of 2/22/25, V13 called V2 at home and said that V28 had called and asked V13 to change R1's television channel. R1 was on the phone with V28 when V13 went into R1's room to change the channel. V2 stated V13 said V28 called back and accused V13 of being rude, hateful, and yelling at R1. V2 stated V13 denied being rude/hateful or yelling at R1 and V13 stated that V28 later came in and apologized saying V28 has a hard time hearing on the phone. V2 stated V2 reported this to V1 on 2/24/25 and did not consider this an abuse allegation since R1's family never reported this and V28 apologized to V13. On 3/17/25 at 3:20 PM V1 stated V1 was not aware that V28 alleged that V13 yelled at R1. V1 confirmed this was not reported to (state surveying agency). 3.) R6's MDS dated [DATE] documents R6 has severe cognitive impairment. On 3/19/25 at 9:04 AM V19 (CNA) stated on 1/18/25 R6 told V19 that another unidentified resident had hit R6. V19 stated this was reported to V1, it was investigated, and it was unfounded. On 3/19/25 at 11:48 AM V1 stated nothing had been reported that R6 alleged another resident hit R6. V1 confirmed this was not included on the facility's abuse log as being reported to (state surveying agency) and confirmed it should have been reported.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to investigate allegations of abuse and to implement protective measures following reported allegations of abuse for three (R1, R2, R6) of eight residents reviewed for abuse in the sample list of 12. Findings include: The facility's Abuse Prohibition policy dated 3/15/18 documents after allegations of abuse are reported to the (state surveying agency), the alleged incident will be investigated by the Administrator or designee and the results of the investigation will be reported to (state surveying agency). The Administrator is responsible for protecting the resident from retaliation during and after the investigation. When an employee is the alleged perpetrator of the abuse, the employee shall be immediately barred from any further contact with residents in the facility until the outcome of the investigation is determined. The facility's Abuse Tracking Log with last recorded entry as 5/5/24 does not document any allegations of abuse involving R1, R2, or R6. 1.) On 3/17/25 at 11:29 AM V26 (R2's Family) stated R2 often complained of unidentified staff squeezing R2 during cares, which has been reported to management and administration. R2's Minimum Data Set (MDS) dated [DATE] documents R2 has severe cognitive impairment, requires substantial/maximal assistance of staff for toileting and bed mobility, and is dependent on s staff for transfers. R2's active Care Plan documents R2 admitted to the facility on [DATE]. This Care Plan documents R2 has delirium or acute delusional episodes, makes untrue statements, and believes things have actually occurred despite reassurance from staff. This Care Plan does not identify what specific accusations or false statements R2 makes. On 3/17/25 at 1:17 PM V13 (Registered Nurse) stated within the last year R2 voiced complaints during night shift that a pregnant woman would come into R2's room at night and abuse R2. V13 stated V8 (Certified Nursing Assistant/CNA) was pregnant at that time but did not work on R2's hallway, and V8 was no longer allowed to take care of R2 after that. V13 stated V2 (Director of Nursing/DON) was aware of R2's accusations, interviewed staff and implemented using two staff for R2's cares. On 3/17/25 at 3:35 PM V2 stated staff have been using two people when providing R2's cares due to R2's history of making false statements. V2 stated R2 would say men were going into R2's room, but we had no men on staff. V2 stated R2 would speak in Spanish to R2's family saying unidentified staff were rough with R2, and both things were reported to V1 (Administrator). On 3/18/25 at 8:54 AM V22 (CNA) stated R2 has made allegations since June 2024 that men would come into R2's room and rape R2. V22 stated the nurses were aware, but V22 never reported this to V1 or V2. V22 stated the facility had one male CNA at that time who never took care of R2. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 at 9:13 AM V8 (CNA) stated V8 was not allowed to take care of R2 after R2 accused V8 of pinching R2 sometime in August 2024. V8 stated R2 also made allegations of rape during the night shift and in the hallways, and men weren't allowed to care of R2. V8 stated V1 and V2 were aware because they asked V8 questions about R2's rape statements. On 3/18/25 at 1:50 PM V1 confirmed the facility's abuse log did not include any abuse allegations involving R2 between January 2024 and March 2025 V1 stated V1 was not aware of R2's allegations of men going into R2's room, rape, or that staff are rough and pinching R2. V1 confirmed these allegations were not investigated and V8 was not placed on leave since an investigation was never completed. 2.) On 3/17/25 at 12:40 PM V28 (R1's Family) stated on 2/22/25 V28 called the facility and asked for R1's television (TV) channel to be changed. V28 stated V28 was on the phone and overhead a nurse come into R1's room, the nurse was snarky and yelled Ok (R1), I gotta change this TV because (V28) wants me to. V28 stated V28 called the facility and spoke to V13 (Registered Nurse), who confirmed V13 was the person in R1's room who changed R1's TV channel while V28 was on the phone with R1. V28 stated V28 reported this to V1 (Administrator) and V18 (Corporate Senior [NAME] President of Clinical Operations). R1's MDS dated [DATE] documents R1 has moderate cognitive impairment. On 3/17/25 at 1:17 PM V13 stated V28 called the facility and asked for R1's television channel to be changed. V13 stated V13 went to R1's room and changed the TV channel and R1 was on the phone at that time. V13 stated V13 might have been loud when talking to R1 but denied yelling at R1. V28 called back and insinuated V13 was being rude to R1 and V13 reported this to V2 (DON). On 3/17/25 at 2:43 PM V18 stated on 3/10/25 V28 contacted V18 and said that V28 had asked V13 to change R1's television channel and V28 asked V13 why V13 was rude and yelled at R1. V18 stated V18 spoke with V1 and V2, who had already addressed V28's concerns. On 3/17/25 at 3:35 PM V2 (DON) stated on the weekend of 2/22/25, V13 called V2 at home and said that V28 had called and asked V13 to change R1's television channel. R1 was on the phone with V28 when V13 went into R1's room to change the channel. V2 stated V13 said V28 called back and accused V13 of being rude, hateful, and yelling at R1. V2 stated V13 denied being rude/hateful or yelling at R1 and V13 stated that V28 later came in and apologized saying V28 has a hard time hearing on the phone. V2 stated V2 reported this to V1 on 2/24/25 and did not consider this an abuse allegation since R1's family never reported this and V28 apologized. On 3/17/25 at 3:20 PM V1 stated V1 was not aware that V28 alleged that V13 yelled at R1. V1 confirmed this was not investigated. On 3/18/25 at 1:50 PM V1 confirmed V13 was not placed on leave since this allegation was not investigated. 3.) R6's MDS dated [DATE] documents R6 has severe cognitive impairment. On 3/19/25 at 9:04 AM V19 (CNA) stated on 1/18/25 R6 told V19 that another unidentified resident had hit R6. V19 stated this was reported to V1, it was looked into, and it was unfounded. On 3/19/25 at 11:48 AM V1 stated nothing had been reported that R6 alleged another resident hit R6. V1 confirmed this was not included on the facility's abuse log as being investigated.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview and record review, the facility failed to implement fall interventions, document a fall in the medical record, perform safe and proper transfers, and thoroughly investigate falls for three (R1, R2, R6) of three residents reviewed for accidents in the sample list of 12. Findings include: The facility's Fall Assessment and Management Policy dated June 2024 documents the following: The resident's care plan will reflect specific needs and risk for falls and all staff who provide resident care will have access to the care plan and/or (electronic care report). Interventions will be based on the fall risk assessment and circumstances of each fall. The nurse will assess the resident following a fall and document on the resident's condition for 72 hours after the incident. The facility's Safe Resident Handling Program dated 3/18/18 documents the resident transfer status will be documented on the resident's plan of care and reviewed via the care plan time frames and as needed. This policy documents gait belts are required for transfers except when using a mechanical lift. 1.) R1's Minimum Data Set (MDS) dated [DATE] documents R1 has moderate cognitive impairment, has impaired range of motion affection one side upper and lower extremity, and is dependent on staff for transfers. R1's Care Plan dated 3/4/25 documents R1 had a stroke that affects R1's left side. R1's Fall Report dated 7/28/24 at 5:51 PM documents V13 (Registered Nurse/RN) was alerted that R1 was on the floor. V29 (Certified Nursing Assistant/CNA) was assisting R1 into the recliner with the sit to stand lift at the time of R1's fall. R1 was seated in the recliner and started to fall as V29 removed the stand lift. V29 lowered R1 to the ground. This fall is not documented in R1's medical record. On 3/19/25 at 10:34 AM V3 (Assistant Director of Nursing/ADON) stated falls should be documented in a nursing note and the fall report is part of risk management, which is not part of the resident's medical record. V3 stated the fall reports used to have a check box that needed to be marked in order for a nursing note to populate a note in the resident's medical record. 2.) R2's MDS dated [DATE] documents R2 has severe cognitive impairment, is frequently incontinent of bowel and bladder, and requires substantial/maximal assistance for toileting and is dependent on staff for transfers. R2's Care Plan dated 1/14/25 documents R2 makes accusatory statements and has behaviors of being aggressive and resistive with cares. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Fall Report dated 6/4/24 documents at 3:30 AM R2 was heard yelling that R2 needed to get up. R2 was found on the floor with her back against the recliner. There are no staff statements or interviews to determine when R2 was last observed or toileted prior to the fall. R2's Fall Report dated 2/8/25 at 6:23 PM documents staff alerted V30 (RN) that R2 was on the floor. R2 was found lying on the floor in front of R2's recliner. V20 (CNA) told V30 that V20 was assisting R2 into the chair, R2 lost balance, and V20 lowered R2 to the floor. V20 was reminded that R2 requires assistance of two for transfers due to behaviors and history of R2 sliding. On 3/18/25 at 4:31 PM V20 (CNA) stated R2 fell a few weeks ago when V20 was assisting R2 onto the toilet. V20 stated V20 transferred R2 by herself and did not use any assistive devices including a gait belt. V20 stated after the fall V20 was told that R2 was to have two staff for transfers and V20 was not aware of this prior to R2's fall. On 3/19/25 at 10:34 AM V3 confirmed R2 should have had two staff assisting for R2's sit to stand lift transfer/fall on 2/8/25. At 11:55 AM V3 reviewed R2's 6/4/24 fall investigation. V3 confirmed the 6/4/24 was unwitnessed and the fall investigation is not thorough and does not include staff statements or interviews to determine when R2 was last observed or provided incontinence cares prior to the fall. 3.) R6's MDS dated [DATE] documents R6 has severe cognitive impairment, is frequently incontinent of bowel and bladder, requires substantial/maximal assistance of staff with transfers, and is dependent on staff for toileting. R6's Care Plan dated 5/16/24 documents R6 is at risk for falls and includes an intervention dated 2/11/25 for a nonskid mat in the wheelchair and recliner. R6's Care Plan dated 11/4/24 documents R6 has fractures of C7-T1, and C3-C5 related to a fall. R6's Fall Report dated 12/15/24 at 5:30 PM documents an unidentified (CNA) alerted V13 (RN) that R6 was found on the floor next to the bed in R6's room. R6 reported to the staff that R6 went to go to bed and R6's shoes started to slide. There are no staff statements or interviews documented to include R6's footwear at the time of the fall or when staff last observed R6 and provided toileting assistance prior to R6's fall. R6's Fall Report dated 2/6/25 at 5:00 PM documents R6 was found lying on the floor partially on R6's right side. R6 reported that R6 was trying to stand up to go to the bathroom, the floor was slick and R6 slipped. A nonskid mat was placed in R6's wheelchair seat as the post fall intervention. R6's Nursing Note dated 2/6/2025 at 5:20 PM documents R6's fall occurred in the dining room. There are no documented statements or interviews with staff to determine when R6 was last observed or provided toileting assistance prior to the fall. R6's Fall Report dated 2/24/25 at 2:10 PM documents R6 was heard yelling help from R6's room and was found lying on his right side in the doorway of his room. R6 was bleeding from cuts to the right eyebrow and right hand. There are no documented staff interviews or witness statements to identify when R6 was last observed by staff or provided toileting prior to R6's fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145470	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Health-Hoopeston	423 North Dixie Highway Hoopeston, IL 60942

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/25 between 11:39 AM and 12:15 PM R6 was sitting in a wheelchair in the dining room eating lunch. At 1:26 PM R6 was lying in bed asleep. R6's wheelchair did not contain a nonskid mat. V8 (CNA) stated R6 uses a bed alarm and V20 thought that was the only fall intervention that R6 uses. V6 stated V6 was not aware of R6 using a nonskid mat in the wheelchair and confirmed R6's wheelchair did not contain a nonskid mat. V20 stated fall information is kept in a binder at the nurse's station. This binder was reviewed with V20 and did not list a nonskid mat for R6. At 1:35 PM V13 (RN) stated V13 looks at the resident's care plan to determine fall interventions. V13 stated V13 did not realize that R6 was supposed to have a nonskid mat. On 3/18/25 at 2:21 PM V3 (Assistant Director of Nursing) stated the antiskid device was a post fall intervention and should still be in the seat of R6's wheelchair. On 3/19/25 at 11:55 AM V3 stated after R6's fall on 11/3/24 R6 has declined and requires staff assistance for all Activities of Daily Living. V3 confirmed R6's falls on 12/15/24, 2/6/25 and 2/24/25 were all unwitnessed and there is no documentation of when staff last observed R6 or provided toileting prior to each of these falls.