STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145031	A. BUILDING _____ B. WING _____	11/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF NORMAL	510 BROADWAY NORMAL, IL 61761

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F 441	Continued From page 12 E2, Director of Nursing, stated on 11/27/12 at 9:20am that R4 continues to be symptomatic with C-diff. E2 stated she would expect staff to wear gowns whenever there is any possiblity of resident contact. E2 stated she would expect protective gown and gloves to be worn during repositioning and also during range of motion. The facility policy titled "Transmission-Based Precautions" dated 6/2/06 states, "Wear gown only when clothing anticipated to come in contact with the patient, environmental surfaces or items in room contaminated with organism..."	F 441		
F9999	FINAL OBSERVATIONS Licensure VIOLATIONS 300.1210b) 300.1210d)6 300.3240 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,	F9999		

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F9999	Continued From page 13 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) These Requirements were not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a safe transfer to prevent injury for one of 7 residents reviewed for falls (R3), out of a sample of 18, by failing to transfer R3 with two staff persons as required. This failure resulted in a patellar fracture requiring orthopedic treatment for R3. The facility failed to use a gait belt during ambulation for one of 7 residents(R9) reviewed for falls. The facility staff failed to apply protective arm sleeves, to prevent skin tears for one resident (R12) in the sample of 18. Findings include: 1. According to the current Physician's Orders, R3 has multiple diagnoses including Cancer with	F9999		

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Metastasis, Anxiety, Right Hemiplegia due to Motor Vehicle Accident, Lack of Coordination, and Ankle/foot Contracture. The Minimum Data Sets (MDS) for 6/7/12 and 11/6/12 assess R3 with minimal cognitive impairment, and extensive assistance of two staff for bed mobility, transfers and toileting. The current Task list on the electronic medical record shows R3 to be a fall risk.

Nursing progress notes dated 8/13/12 at 9:29am and 9:34am state that the CNA (Certified Nurse Aide) reported that R3 was on the commode and R3 heard her knee "pop" and "crack." R3 complained of pain but would not allow the nurse to examine R3. A portable x-ray was done later on 8/13/12.

On 8/14/12 Z1 (attending physician) examined R3 at the facility and wrote, "sprain {right} knee, possible patellar fracture." Z1 ordered non-weightbearing status and referred R3 to Z2 (Orthopedist) On 8/16/12, Z2's examination noted a twisting type injury and stated "{R3} was being transferred to the commode and pivoted with her foot planted and felt and heard a pop." Z2 noted a right knee nondisplaced patella fracture, and ordered a long leg splint.

The Statement by Witness by E4 (CNA) in the facility's incident investigation dated 8/13/12 states that R3 wanted to use the commode. There were no other CNAs available at that time so E4 offered R3 the bedpan. R3 refused the bedpan and stated she was strong enough to assist with a pivot transfer. E4 stated they stood up together with R3 standing on her left leg. When E4 started to lower R3 to the commode,

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R3 "began moving her legs, making the lowering difficult for me. She was no longer bearing her own weight. I had to catch her and move commode closer to keep her from falling on the commode. Once seated on the commode, I heard a POP. . . . .{R3}didn't know which leg it was. . . ." The facility's investigation concluded on 8/24/12 that E4 did an improper transfer of R3 and received education and discipline.

On 11/27/12 at 12:00pm E4 confirmed information in the written statement. E4 stated that when she was starting to ease R3 down to the commode, R3 started to "move away from me, and I had to reach to get the commode under her." When E4 eased her down onto the commode, that's when E4 heard the pop. R3 yelled in pain, but could not tell which knee it was at first. E4 stated that R3 did require two people for transfers, but that sometimes some people did transfer R3 with just one person. E4 also stated that they used the stand-lift with R3, but that R3 did not like to use it.

On 11/27/12 at 11:20am, E3 (Assistant Director of Nursing) stated that R3 had been a sit-to-stand lift but the right leg was getting progressively weaker. E3 stated that "on a good day" R3 was a two-person lift, and that at the very least, R3 should have had two staff to transfer.

2. R12 has diagnoses which includes Osteoporosis, Depression, and Muscle Weakness. R12's annual Minimum Data Set dated 10/27/12 identified R12 with severe cognitive impairment, requires extensive assist of two staff for transfers, is lifted via mechanical lift, and had sustained skin tears within the

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assessment period. R12 has a physician's order dated 12/31/12 for "Geri" (Geriatric) sleeve on at all times. Nurse's notes document R12 had sustained recent skin tears to the right forearm on 10/07/12 . The 11/06/12 skin notes documented the skin tear was resolved on 11/06/12 resident to wear geriatric sleeves to both upper extremities.

On 11/27/12 at 1:10 pm R12 was seated in her wheelchair in the corridor on the Rehab wing. R12 had a blood stain on the sleeve of her long sleeved shirt over her left forearm. R12 was wearing a geriatric sleeve on the right forearm under her shirt but no protective sleeve on the left arm.The bloodstain was shown to Certified Nurse Aide (CNA) E17. When E17 pulled up R12's shirt sleeve a fresh U shaped skin tear was on R12's forearm. E17 stated that R12 is supposed to have a geri sleeve on both arms. E17 did not know why she was not wearing one. E17 then notified a Nurse of the new skin tear.

On 11/28/12 at 10:55 am E17 stated she had not noticed that R12 wasn't wearing a geri sleeve on her left arm on 11/27/12 when she transferred R12 from the bed to her wheelchair with the lift in the morning. E17 stated that she had not gotten R12 dressed, the night shift had dressed R12. E17 stated she knows R12 needs both arms covered but she did not think it was on the careplan. On 11/28/12 at 11:00 am E17 pulled up R12's Kardex on the hall monitor screen. The skin care plan for R12 included "bilateral upper extremity geriatric sleeves."

The 11/27/12 nurse's note documented a Skin Assessment was done related to a newly acquired Skin Tear to Left Forearm. The area

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measured 1.8 x .1 cm. The note stated Steristrips were used and Geriatric sleeves were applied to both upper extremities.

3. R9 was admitted to the facility on 9/18/12. The Physician's Order Sheet for November 2012 indicates that R9's diagnoses include Degeneration of Lumbar Sacral Disc and Chronic Low Back Pain. The Resident Assessment Instrument (RAI) of 11/18/12 indicates R9 is cognitively impaired and requires extensive assistance of one for transfers, ambulation, and activities of daily living. The RAI indicates R9 is "not steady and only able to stabilize with staff." The Fall Assessment Reports dated 9/26/12, 10/2/12 and 10/22/12 state R9 had falls on those dates. The Care Plan dated 9/18/12 states R9 is "at risk for falls due to unsteady gait." Fall Assessment of 10/22/12 documents R9's Physical Performance Limitations as "difficulty maintaining standing position, impaired balance during transitions" and that R9 "has a history of being impulsive with poor safety awareness."

On 11/26/12 at 11:55 am CNA, E10 and R9 were walking out of the residents bathroom. R9 was using her walker with E10 walking behind. No gait belt was on R9. On 11/26/12 at 11:57am E10 stated, "I did not use a gait belt assisting resident to the bathroom."

On 11/26/12 at 1:05 pm Physical Therapist, E12, stated "a gait belt should be used at all times for (R9)." E12 stated that R9 is currently receiving physical therapy five times a week for strength building and safety with transfers so she can walk with walker on her own.

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