STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145038	A. BUILDING _____ B. WING _____	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF DECATUR	444 WEST HARRISON STREET DECATUR, IL 62526

(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) COMPLETION DATE
F 371	Continued From page 9 to have a dripping area from the overhead condenser line directly over an open box of ham patties. The back wall of the freezer area had an ice buildup that E3 stated she was unaware of which had built up behind the condenser along the wall. 2. On 11-27-12 at 9:50am with E4, Assistant Dietary Manager, the walk in cooler was identified to have a water drip coming down from the condenser line directly over food stored on shelving. A pan with Sweet Potato Casserole was directly under the condenser line and two puddles of water had collected on the foil lid covering the pan. E4 stated she was unaware of this drip. 3. On 11-27-12 at 1:55pm with E4 four of 6 knives had dried on food debris present. 4. On 11-27-12 at 1:55pm with E4 the storage of utensils resulted in 2 serving scoops and 1 gravy ladel that had dried food debris in the metal bowl portions of the utensils. There were 7 of 8 bowl scrapers that had rough broken edges that were no longer easily cleanable. 5. On 11-27-12 at 2:30 pm the can opener blade surface had a dark thick build up on the upper 1/8 inch of the blade near the metal housing. According to the Centers for Medicare and Medicaid Services 672 form completed 11-27-12 there are 101 residents living in the facility.	F 371		
F9999	FINAL OBSERVATIONS Licensure VIOLATIONS:	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145038	A. BUILDING _____ B. WING _____	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF DECATUR	444 WEST HARRISON STREET DECATUR, IL 62526

(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) COMPLETION DATE
F9999	Continued From page 10	F9999		

300.1210b)
300.1210d)6
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.
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 as evidenced by:

Based on record review and interview the facility failed to provide supervision to R3 during a catastrophic (significant behavioral) event resulting in R3 slamming her right index finger into another resident's door which resulted in partial amputation of the right index finger. The facility failed to provide safe transfers from a mechanical lift to R6's bed which resulted in R6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145038	A. BUILDING _____ B. WING _____	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF DECATUR	444 WEST HARRISON STREET DECATUR, IL 62526

(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) COMPLETION DATE
F9999	Continued From page 11	F9999		

sustaining a fractured tibia during the second transfer. R3 is one of three residents reviewed for behaviors in the sample of 21, and R6 is one of 10 residents reviewed for falls and fractures in the sample 21.

Findings include:

1. The Physician's Order Sheet dated November 2012 lists the following diagnoses for R3: Alzheimer's Disease, Dementia with Agitation and Failure to Thrive. The MDS (Minimum Data Set) dated 10/16/12 states R3 is severely impaired in daily decision making skills, and displays physical and verbal behaviors which occur on a daily basis and impact both R3 and other residents.

The facility's report titled "Incident Report-Patient Involved" dated 3/18/12 documents R3 had an incident on 3/18/12 at 6:45 PM under the section titled "Incident Description and Investigation". This section states R3 was standing at another residents' door attempting to push the door open and a CNA (Certified Nursing Assistant) was trying to redirect R3 away from the door. When the CNA approached the door R3's right index finger was in the door bleeding and injured. The facility's form titled "Witness Statement" by Z3, Daughter of R31, states Z3 was putting her mother to bed and R3 came into R31's room stating R3 needed to talk to Z3 and wanted Z3 to help R3. Z3 told R3 she could not help her and would need to go to the nurses station to call R3's husband. R3 started to leave R31's room, changed her mind, and headed back into R31's room. Z3 closed the door. R3 pushed the door open and stated to Z3 to not close the door in her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145038	A. BUILDING _____ B. WING _____	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF DECATUR	444 WEST HARRISON STREET DECATUR, IL 62526

(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) COMPLETION DATE
F9999	Continued From page 12	F9999		

face. Z3 tried to hold the door closed. R3 reached in and smacked Z3's face. Z3 stated she yelled for help (no staff was available) and pushed the door closed. R3 pushed the door open again not knowing R3's finger was in the door. The Facility's Witness Statement by E17, LPN (Licensed Practical Nurse), states " (R3) was on the locked Alzheimer's unit due to some increased behaviors.....Around 6:30 PM I exited the Alzheimer's unit with (R3) to take her to her room to lay down and provide 1 to 1.....While walking to (R3)'s room (E17) stopped to give (R31's) her medication.... (E17) went to the nurses station to take a long distance phone call from a family member who had been waiting for 20 minutes. (E17) took the phone to another resident's room and was gone for approximately 2-5 minutes and (E17) saw (R3) standing up in front of (R31's) room with (R3's) hands up to the door...when (E17) got to the door (R3's) finger was in the door and blood everywhere."

E1, Administrator stated on 11/29/12 at 1:50 PM "My understanding of the incident is (R3) was following the nurse (E17) with medication pass. (E17) received a phone call and (E17) decided to take the phone call and (R3) was left alone for a short period of time.....(E17) made a judgement call to take care of the phone call and was gone. (R3) was not on a formal one to one status but (R3) was to be in a common area to be able to be more supervised and monitored."

The Hospital Report titled "Emergency Room Document" dated 3/18/12 states "Diagnosis" "Final: Right Index Finger Partial Amputation, Additional: Nail Plate and Nail Bed Avulsion Right Index Finger, Open Distal Phalanx Fracture Right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145038	A. BUILDING _____ B. WING _____	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF DECATUR	444 WEST HARRISON STREET DECATUR, IL 62526

(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) COMPLETION DATE
F9999	Continued From page 13 Index Finger." 2. The Physician Order Sheet dated 11/12 for R6 documents reflects the following diagnoses: Infantile Cerebral Palsy, Scoliosis, Asthma, Speech Disturbance, Gastroesophageal Reflux Disease, Tracheostomy, Gastrostomy, Spinal Fusion and Constipation. The Minimum Data Set for R6 dated 11/9/12 documents R6's functional status for transfers as total dependence, using full staff performance. A. The Facility's report titled Incident Report - Patient Involved dated 1/27/12 for R6 documents a transfer involving R6 with a mechanical lift. According to the report during the transfer to R6's bed, E15 and E16 (Certified Nursing Assistants) lowered R6's bed and did not move R6's feeding pump from the downward path of the bed, causing the feeding pump to fall and strike R6 across her left cheek. On 11/29/12 E2 (Director of Nursing) at 11:00 a.m. acknowledged that E15 and E16 (Certified Nursing Assistants) were interviewed about the incident and should have placed the feeding pump out of the way before lowering the bed during the transfer of R6. B. Nursing Notes signed by E21 (Registered Nurse) dated 1/29/12 document that during care R6 was noted to have a discoloration on her left knee and left ankle, and was sent out to the Emergency Room for evaluation and treatment. R6 returned 1/29/12 with a brace on her left leg and a diagnosis of acute Left Proximal Tibia Fracture.	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145038	A. BUILDING _____ B. WING _____	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF DECATUR	444 WEST HARRISON STREET DECATUR, IL 62526

(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) COMPLETION DATE
F9999	Continued From page 14 The Facility Incident Report - Patient Involved dated 1/29/12 for R6 documents an investigation into the discoloration of R6's left knee and ankle. The investigation concludes that during a transfer with a mechanical lift on 1/28/12, E7 and E8 (Certified Nursing Assistants) did an improper transfer that caused R6 to sustain an acute left proximal tibia fracture. On 11/29/12 E1 (Administrator) at 11:40 a.m. stated that E7 and E8 (Certified Nursing Assistants) were terminated for their actions during the 1/28/12 transfer of R6. C. The Facility's report titled Incident Report - Patient Involved dated 2/14/12 for R6 documents that R6's arms were not safe guarded by E19 and E20 (Certified Nursing Assistants) during a mechanical lift transfer. R6's right arm flung out involuntarily and her right hand was caught under the bar of the mechanical lift when she was being lowered, causing bruising and swelling. On 11/29/12 at 11:00 a.m. E2 (Director of Nursing) acknowledged that E19 and E20 (Certified Nursing Assistants) should have safe guarded R6's arms and had performed an improper transfer, resulting in a bruised and swollen right hand. (B)	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145038	A. BUILDING _____ B. WING _____	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF DECATUR	444 WEST HARRISON STREET DECATUR, IL 62526

(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) COMPLETION DATE
F9999	Continued From page 15	F9999		

Section 300.2010 Director of Food Services

a) A full-time person, qualified by training and experience, shall be responsible for the total food and nutrition services of the facility. This person shall be on duty a minimum of 40 hours each week.

1) This person shall be either a dietitian or a dietetic service supervisor.

This requirement is not met as evidenced by:

Based on interview and record review the facility failed to have a full time qualified person responsible for the management duties of the dietary department that has completed the required 90 hour training to be a qualified dietary manager.

Findings include:

On 11-27-12 at 9:50am Z2, Consultant Registered Dietitian, stated she was aware that neither E3, Dietary Manager (DM), nor E4, Asst. Dietary Manager (ADM), had completed the 90 hour food service course.

On 11-27-12 at 10:00am E4 stated she has not enrolled in the dietary manager's course as of this date.

On 11-27-12 at 2:00pm E3 stated she has not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145038	A. BUILDING _____ B. WING _____	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF DECATUR	**444 WEST HARRISON STREET DECATUR, IL 62526**

(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) COMPLETION DATE
F9999	Continued From page 16 enrolled in the dietary manager's course as of this date. According to employment records, the last qualified Dietary Manager the facility had employed was E14 and her last day of work was 8/21/12. (B)	F9999		