STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145016	A. BUILDING _____ B. WING _____	02/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-BLOOMINGTON	700 EAST WALNUT BLOOMINGTON, IL 61701

(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 323	Continued From page 3 falls. She stated that after the fall on 4/21/12 she had updated R1's Plan of Care and instructed the staff to inform R1's visitors to notify the staff when leaving so staff could attend to R1. E2 stated "I did not want (R1) to be left alone because she would try to transfer herself."	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210b)6) 300.1220 b)3) 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 300.1220 Supervision of Nursing Services	F9999		

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F9999	Continued From page 4 b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 Regulations were not met as evidenced by: Based on record review and interview the facility failed to ensure that one (R1) of four residents reviewed for falls in a sample of 15 was properly supervised during toileting. This failure resulted in R1 falling from the commode and sustaining a head laceration and subdural hematoma. Findings include: The Physician Order Sheet dated February 2013	F9999		

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F9999	Continued From page 5	F9999		

for R1 documents the following diagnoses: Cerebral Artery Occlusion with Infarct, Depression, and Osteoporosis.

R1's Minimum Data Set (MDS) dated 4/8/12 under Brief Interview for Mental Status assesses R1 as having severe cognitive impairment. The MDS documents under Functional Status that R1 is not steady, only able to stabilize with staff when moving on and off the toilet and that there is impairment to one side, upper (shoulder, elbow, wrist and hand) and lower extremities (hip, knee ankle and foot). The MDS documents a previous fall with injury.

On 2/8/13 at 12:40 pm E4 (Minimum Data Set Coordinator and Registered Nurse) stated that she had assessed R1's functional ability through direct observation and information received from other staff. The information was then entered into the Minimum Data Set dated 4/8/12. E4 stated R1 required assistance of one for all transfers during this time of resident assessment (4/8/12).

The facility document titled Fall Assessment and dated 3/30/12 for R1 reflects a previous fall and per the facility document automatically makes a resident high risk for falls.

The facility's fall occurrence reports dated 2/4/12, 4/21/12 and 4/27/12 document the following falls for R1: On 2/4/12 R1slid from her wheelchair sustaining a laceration to her left forearm. On 4/21/12 R1 stood up from her wheelchair and fell. On 4/27/12 R1 was toileted by E3 (Certified Nursing Assistant) and was left alone while on the toilet. R1 was found on the floor and was noted to have a gash to the left forehead area and blood

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F9999	Continued From page 6	F9999		

was noted on the floor. E2 (Director of Nursing) documents "Resident fell off of toilet while reaching for something. Resident has poor safety awareness and is impulsive....resident needs one assist for transfers....staff momentarily left resident on toilet to tend to another resident." R1 was transferred to the hospital for evaluation and treatment of laceration.

The hospital emergency room notes dated 4/27/12 documents the following: Computerized Tomography of R1's head reflects "a small left temporoparietal subacute subdural hematoma and a right sylvan fissure subarachnoid hemorrhage is seen. Encephalomalacia is present in the the right Middle Cerebral Artery (MCA) territory as described." Emergency Room discharge diagnoses reflect: Closed Head Injury, Facial Laceration, Cerebral Vascular Accident (cerebral infarction), Intracranial bleeding and Coagulopathy. R1 was transported back to the facility on 4/27/12 per emergency room notes.

A hospital document titled History and Physical Exam - Neurosurgeon and dated 6/5/12 documents R1 having sleepiness and increased subdural hygroma. A Computerized Tomography of R1's head and dated 6/5/12 states "Demonstrates chronic hygromatous fluid increasing in thickness, measuring 1.7 centimeters in greatest diameter. Ventricles appear stable in size. Continued appearance of right-sided MCA infarct. Very mild midline shift. Assessment: Left Subdural hematoma - -worsening Plan: Admit with Burr hole evacuation tomorrow." The reports are signed by Z1 (Neurosurgeon). Hospital records document R1's admit on 6/5/12 and discharge back to the facility

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F9999	Continued From page 7 on 6/8/12 after a Burr hole evacuation of a hematoma sustained on 4/27/12. On 2/7/13 at 9:45 am E2 stated that E3 should not have left R1 on the toilet by herself on 4/27/12 due to her cognitive status and E3 had used bad judgement. E2 stated that E3 had been disciplined and stated "I can not control everything my staff does." At 1:20 pm on 2/7/13 E2 described the interventions put in R1's plan of care concerning falls. She stated that after the fall on 4/21/12 she had updated R1's Plan of Care and instructed the staff to inform R1's visitors to notify the staff when leaving so staff could attend to R1. E2 stated "I did not want (R1) to be left alone because she would try to transfer herself." (A)	F9999		