

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6000285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/08/2014
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NAME OF PROVIDER OR SUPPLIER HEARTLAND OF DECATUR	STREET ADDRESS, CITY, STATE, ZIP CODE 444 WEST HARRISON STREET DECATUR, IL 62526
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S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS:</p> <p>300.1210a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p>	S9999		

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

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S9999	<p>Continued From page 1</p> <p>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:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review the facility failed to maintain a safe environment by leaving R3 unattended in the bathroom, and failing to supervise and implement effective fall interventions for one of three residents (R3) reviewed for falls in a sample of six. This failure for R3 resulted in fractured fibula requiring hospital treatment.</p> <p>Findings include:</p> <p>1. The hospital Discharge Summary, 1/24/14, documents R3's discharge to the facility was delayed due to a fall at the hospital on 1/23/14. R3 was transferred to the facility on 1/24/14. The facility Admission Record dated 1/24/14, documents R3 with diagnoses to include dementia, abnormal gait, muscle weakness and convulsions. R3's Admission Screening, 1/24/14, documents R3 with moderately impaired cognition and at risk for falls due to a history of falls, muscle weakness, incontinence, psychotropic medication use, and other</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>underlying health conditions. The facility kardex and careplan dated 1/24/14, documents R3 as at risk for falls, with interventions including a low bed, meals in the dining room, have commonly used articles within reach, and toilet before bed.</p> <p>The facility Incident Report dated 2/6/14 at 11:00pm, completed by E9 (Nurse) documents R3 as being found on the floor by E5 (Nursing Assistant). The Statement, 2/6/14, by E5 documents "I went to answer the call light and I observed (R3) on the floor by the bed and commode." Another Statement by E5 on 2/12/14, documents "I put R3 on the commode and (R3) had her call light. . ." E5 went to assist another resident and when E5 returned R3 was on the ground. The Progress Note, 2/6/14, completed by E9 documents R3 was sent to the emergency room. The hospital emergency room report, 2/6/14, documents R3 with a fracture to the left distal fibula and a splint was applied.</p> <p>On 7/8/14 at 11:35am, E9 stated R3 was placed on a commode by E5 on 2/6/14. R3 was asked to wait for assistance. R3 attempted to transfer without assistance and was found on the floor by E5. R3 was confused and a fairly new admission to the facility. E9 stated residents with cognitive deficits should not be left unattended on the commode.</p> <p>On 7/3/14 at 2:31pm, E5 stated R3 had activated the call light. E5 answered the light and assisted R3 to the bedside commode. E5 stated R3 was left on the commode alone to assist another resident who was a fall risk. While E5 was assisting the other resident R3 fell trying to transfer back to the bed without assistance. E5 stated residents at fall risk are not to be left alone on the commode. E5 stated nursing assistants</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>identify residents at risk for falls on the kardex. E5 stated she was unaware R3 was at risk for falls at the time of the fall on 2/6/14.</p> <p>The facility Investigative Report of R3's fall on 2/6/14, completed on 2/13/14, documents a conclusion as R3 was found on the floor in room after trying to self transfer from a bedside commode. R3 has multiple risk factors. R3 will be assisted to and from the commode for safety.</p> <p>On 7/8/14 at 1:20pm, E2 (Director of Nursing) stated after the fall on 2/6/14 the intervention placed was to assist R3 when using the commode. E2 stated the intervention placed to assist R3 on and off the commode was a practice which should have been followed by E5 at the time of R3's fall on 2/6/14. R3 should not have been left alone on the commode. E2 could not provide the reason E5 left R3 alone on the commode.</p> <p>On 7/8/14 at 1:55pm, Z4 (Physician), stated R3 staff should try not to leave residents alone on the commode. Z4 also stated that in order to keep R3 safe she would need to remain one to one with staff and that was not possible.</p> <p>2. The facility Incident Report, 3/20/14 at 5:30pm, documents R3 with an unwitnessed fall. The Investigative Report, 3/2014, documents R3 was last observed by staff eating dinner twenty minutes before the fall. The intervention placed was to assist R3 to the bed after the evening meal.</p> <p>On 7/8/14 at 1:20pm, E2 (Director of Nursing) stated R3 was to be assisted back to bed after the evening meal. R3 was last observed 20 minutes before the fall eating dinner in the</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>bedroom. E2 could not indicate how this would be effective since R3's last observation by staff was when R3 was eating dinner.</p> <p>3. The facility Incident Report, 3/22/14 at 10:40pm, completed by E12 (Nurse), documents an unwitnessed fall; R3 was found on the floor in the bedroom. R3 reported she was trying to go to the bathroom and slipped. The intervention documented by E12 at the time of the fall was the bed was placed in low position. The Investigative Report, 3/24/14, documents toilet R3 before bed as an added intervention.</p> <p>On 7/3/14 at 12:10pm, E2 stated the last time R3 was taken to the bathroom prior to the fall is not known and not documented. On 7/8/14 at 1:20pm, E2 could not indicate if R3's bed was already in low position per the plan of care at the time of the fall on 3/22/14. E2 could not provide information as to why E12 lowered the bed after the fall when the low bed was an intervention in place at the time of the fall.</p> <p>The facility policy, Fall Practice Guidelines, 2011, documents approaches are selected based on the patient's preferences, risk factors, co-morbid conditions, and willingness to participate with the plan of care. The approaches for fall interventions are clear specific and individualized for the patient's needs.</p> <p>(B)</p> <p>300.610a) 300.696c)4) 300.1210b) 300.1210d)2) 300.1210d)3) 300.3240a)</p>	S9999		
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S9999	<p>Continued From page 5</p> <p>Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.</p> <p>Section 300.696 Infection Control c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340): 4) Guideline for Prevention of Surgical Site Infection</p> <p>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:</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review the facility failed to provide treatment and services to promote healing and prevent infection for post surgical wounds resulting in infection and requiring additional hospital treatment. This affects one of three residents (R2) reviewed for wound treatments in a sample of six.</p> <p>Findings include:</p> <p>The Admitting Record documents R2 was admitted to the facility on 5/2/2014 with diagnoses to include a fracture of the tibia and fibula. The hospital History and Physical dated 4/26/14 by Z1 (Physician), documents R2 required surgical repair of the distal tibia and fibula fracture. The hospital Discharge Instructions dated 5/2/14, document to leave R2's dressing in place for one week then change to a dry dressing daily and as needed.</p> <p>The facility Admission Physician Orders for R2 dated 5/2/14, documents to leave the dressing in</p>	S9999		

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S9999	<p>Continued From page 7</p> <p>place for one week then clean the area with wound cleaner and put a dry dressing on daily and as needed. The Administration Record dated 5/9/14 through 5/18/14, documents only one dressing change on 5/12/14.</p> <p>On 7/3/14 at 2:40pm, E6 (Nurse), stated R2's staples were removed and the wound to the right lateral ankle was cleansed and dressed on 5/12/14.</p> <p>The Physician Visit Report by Z1 dated 5/19/14, documents R2 presenting with "an extremely dirty dressing. It was soaked with purulent drainage." A foul odor was present with drainage from the incision at the lateral ankle and it was documented as infected. The report documents Z1 reported the condition of the wound to the facility. Z1 documents an incision and drainage and antibiotics are needed to treat the wound.</p> <p>The facility Progress Notes, 5/20/14, documents R2 was discharged to home.</p> <p>The hospital Report of Operation dated 5/21/14, documents R2 with a right lateral ankle post surgical infection. A right lateral ankle incision and drainage and placement of a vac dressing was performed. R2 was discharged from the hospital on 5/23/14.</p> <p>On 7/1/14 at 1:53pm, E1 (Administrator) that E2 (Director of Nursing) contacted E1 to report Z1's concern with R2's when Z1 called the facility on 5/19/14. E1 completed an investigation and the facility identified the Administration Record lacked documentation of the dressing changes being completed. The nurses were interviewed, and except for 5/12/14, the facility could not confirm dressing changes were completed as ordered by</p>	S9999		
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S9999	<p>Continued From page 8</p> <p>the physician.</p> <p>On 7/1/14 at 4:30pm, Z1 confirmed that R2 was discharged to the facility with staples to the surgical areas. When R2 presented to the office on 5/19/14 the wound to the right lateral ankle was covered with two dressings and a lot of discharge. The dressing was dirty and the wound odorous. Z1 contacted the facility to report the concerns. After discharge from the facility, R2 required an incision and drainage to clean out the wound, antibiotics and further wound care due to an infection most likely from lack of wound care while residing at the facility. Z1 stated the dressing should have been changed more timely while R2 was at the facility, and that may have prevented the infection or at least identified the infection sooner.</p> <p>On 7/1/14 at 2:46pm E2 stated that lack of documentation on the Administration Record indicates either the treatment wasn't completed or the nurse failed to document the completion of the treatment. All treatments are to be provided per the facility policy for medication administration. Nurses are to follow physician orders.</p> <p>The facility policy for General Dose Preparation and Medication Administration dated 5/1/13, documents that nurses are to document necessary treatment information.</p> <p style="text-align: center;">(B)</p>	S9999		
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