STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145012	A. BUILDING _____ B. WING _____	C 01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF GALESBURG	**280 EAST LOSEY STREET GALESBURG, IL 61401**

(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 000	INITIAL COMMENTS complaint investigation 1720054/IL90849	F 000		
F 155 SS=K	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 155		

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

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F 155	Continued From page 1 information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure all staff had knowledge of the conditions that require initiation of CPR (cardiopulmonary resuscitation) for one of three residents (R1) reviewed for advanced directives/CPR in a sample of three. This failure resulted in R1's advance directives not being honored in that R1 did not receive CPR when R1 suffered respiratory arrest. The failure also has the potential to affect one of three residents (R3) reviewed for advanced directives/CPR in a sample of three and 28 residents (R4-R31) in the supplemental sample. This failure resulted in an immediate jeopardy.	F 155		

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F 155	Continued From page 2	F 155		

While the immediacy was removed on 1-10-2017, the facility remains out of compliance at severity level two as the facility continues to monitor the effectiveness of training regarding staff knowledge of when to initiate CPR.

Findings Include:

The facility policy, entitled "Cardio-Pulmonary Resuscitation [CPR]: Adult", revised 08/2014, documents, "CPR is initiated unless one of three following conditions is present: 1) a valid DNR [Do Not Resuscitate] is in place; 2) initiating CPR could cause injury or peril to the rescuer; or 3) in the presence of obvious signs of clinical death (e.g. [that is], rigor mortis, dependent lividity, decapitation, transection, or decomposition) ...Procedure: upon discovering unresponsive patient with no breathing or no normal breathing, call for help ...initiate compressions ...attach and use AED [automated external defibrillator] ...continue CPR until relieved, spontaneous breathing and, or heart rate resumes or emergency medical personnel arrive and assume control of the situation."

R1's "Routine Physician Orders/MARs [Medication Administration Record]", dated 1/1/2017, document, "Advanced Directives: Full-Code ". R1's medical chart has a full-sized, light purple, sheet of paper the documents "RESIDENT IS A FULL CODE ". R1's "Admission Record Report", dated 1/1/2017, documents, "Current admission date-12/26/2016".

R1's "[Facility initials/city] Progress Notes", dated 1/3/2017, charted by E3 (Licensed Practical Nurse), document, "1745 [5:45 p.m.] this nurse

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F 155	Continued From page 3	F 155		

reentered room to check on the resident and there were 0 respirations, skin cool no VS [vital signs] or heart tones". R1's medical records do not document CPR was ever initiated, or the 911 was ever notified.

On 1/5/2016, at 12:25 p.m., E5 (Registered Nurse/Nurse Manager) confirmed: being the first nurse to find R1 unresponsive, on 1/3/2017 at 5:45 p.m., in R1's bed; R1 was a full code status per R1's chart; CPR should have been started right away; and CPR was not done at any time.

On 1/6/2017, at 12:50 p.m., E5 confirmed R1 did not have any of the "clinical signs" of death according to the aforementioned facility policy.

On 1/5/2017, at 12:00 p.m., E2 (Director of Nursing), confirmed: R1 was admitted on 12/26/2016 from a local hospital; R1 was to be a short-term stay and then be discharged to R1's home; R1 was a full-code status upon admission;R1's code status was on the kardex at the nurse's station, and in R1's room for staff to see; E5 (Registered Nurse) should have started CPR immediately upon finding R1 unresponsive; and E5 should have called for help and notified 911 services.

On 1/5/2017, at 12:44 p.m., E3 confirmed: E3's aforementioned nursing progress notes; R1 was a full code; CPR was not performed on R1; CPR should have been performed on R1; and 911 was not notified.

The facility document, entitled "Record of Death", documents R1's "Date of Death: 1/3/2017 and Hour: 5:45 p.m.".

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F 155	Continued From page 4 On 1/5/2017 at 4:25 p.m., E2 confirmed: E5, being an RN, would respond to any codes in the facility; and there are 29 residents (R3-R31), residing in the facility that have a code status of Full (requiring all life support measures). The Immediate Jeopardy was identified on 1-5-17 at 2:45 PM. The Immediate Jeopardy began on 1-3-17 at 5:45PM when the facility failed to identify when CPR is to be initiated. E1 (Administrator) and E2 (Director of Nursing) were notified of the Immediate Jeopardy on 1-10-17 at 12PM. The surveyor confirmed through observation and interview that the facility took the following actions to remove the Immediate Jeopardy: 1) The DON/designee provided education for licensed staff licensed staff on F-tag 155; that licensed staff provide basic life support, including CPR to a resident requiring such immediate care prior to the arrival of emergency services & subject to the related MD orders and the patient's advance directives; Review of CPR; Adult guideline; Emergency Management Guideline to include documentation of emergency services provided and mock drills; and AED use. Inservice sheets were signed by staff. (Started 1-5-17 and finished 1-10-17) 2) E3 and E5 received 1:1 re-education on the aforementioned training [item 1)]. (Completed On 1/5/2017) 3) Human Resource Department reviewed nursing staff files and composed a list of CPR certification dates, identified staff needing	F 155		

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F 155	Continued From page 5 recertified, and has scheduled CPR instruction for those in need. There will be a verified CPR-trained member of staff on each shift. (Completed On 1/5/2017) 4) Director of Nursing completed an audit of residents' code status and ensured the appropriate color-coded identifiers and Physician Order's for Life-Sustaining Treatment (POLST) forms are on the resident charts. (Completed On 1/5/2017) 5) E2 Director of Nursing and E6 Unit Manager reassessed like residents to identify current CPR status including proper orders. (Completed On 1/9/2017)	F 155		
F 224 SS=G	483.12(a)(1) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN a) The facility must- (1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility neglected to follow their policy regarding Cardio-pulmonary Resuscitation (CPR) initiation, for one of three residents (R1) reviewed for advanced directives/cardiopulmonary resuscitation in a total sample of three. This failure resulted in R1 having no opportunity for resuscitation after experiencing cardiac and respiratory arrest. Findings Include:	F 224		

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Facility policy, entitled, "Patient Protection:Abuse, Neglect, Exploitation, Mistreatment & Misappropriation Prevention", copyright date 2016, documents, "Neglect is the failure of the facility, its employees or service providers to provide goods or services to a resident..."

The facility policy, entitled "Cardio-Pulmonary Resuscitation [CPR]: Adult", revised 08/2014, documents, "CPR is initiated unless one of three following conditions is present: 1) a valid DNR [Do Not Resuscitate] is in place; 2) initiating CPR could cause injury or peril to the rescuer; or 3) in the presence of obvious signs of clinical death (e.g. [that is], rigor mortis, dependent lividity, decapitation, transaction, or decomposition) ...Procedure: upon discovering unresponsive patient with no breathing or no normal breathing, call for help ...initiate compressions ...attach and use AED [automated external defibrillator] ...continue CPR until relieved, spontaneous breathing and, or heart rate resumes or emergency medical personnel arrive and assume control of the situation."

Facility document, entitled [R1's name], dated 12/27/2016, documents R1 is a full code. Per E2 (Director of Nursing), on 1/5/2017, at 12:00 p.m., this document was taped in R1's closet, and located at the nurse's station, and is used as a quick reference to R1 Activities for Daily Living, Safety, Skin Care, and Special Needs Care.

R1's "Routine Physician Orders/MARs [Medication Administration Record]", dated 1/1/2017, documents, "Advanced Directives: Full-Code". R1's "Admission Record Report", dated 1/1/2017, documents, "Current admission

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F 224	Continued From page 7 date-12/26/2016". R1's "[Facility initials/city] Progress Notes", dated 1/3/2017, charted by E3 (Licensed Practical Nurse), document, "1745 [5:45 p.m.] this nurse reentered room to check on the resident and there were 0 respirations, skin cool no VS or heart tones". R1's medical records do not document CPR was ever initiated, or that 911 was ever notified. On 1/5/2017, at 12:00 p.m., E2 (Director of Nursing), confirmed: R1 was a full-code status; E5 (Registered Nurse) did not initiate CPR upon finding R1 unresponsive; E5 should have called for help, started CPR, and notified 911 services. On 1/5/2017, at 12:25 p.m., E5 (Registered Nurse/Nurse Manager) confirmed: being the first nurse to find R1 unresponsive in R1's bed; R1 was a full code status per R1's chart; CPR should have been started right away; and CPR was not done. The facility document, entitled "Record of Death", documents R1's "Date of Death: 1/3/2017 and Hour: 5:45 p.m."	F 224		
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's	F 309		

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F 309	Continued From page 8 comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff provided change in status assessments for one of three residents (R1) reviewed for assessments, in a sample of three. This failure resulted in R1 being found not breathing and without a pulse after a 25 minute period of time between status checks. Findings Include: Physician's order sheet, dated December 2016 documents that R1 has a history of COPD (Chronic Obstructive Pulmonary Disorder). Discharge Summary from the local hospital, dated 12-26-16, documents that R1 had oxygen saturation levels from 92-96% on room air. Skilled Nursing Progress Note, dated 12-27-16 at 10:13 PM, state, "resident is alert and able to make needs known..."	F 309		

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F 309	Continued From page 9 Skilled Nursing Progress Note, dated 12-29-16 at 3 AM, document that R1 is "alert and oriented x3" (to person, place and time). The facility policy, entitled "Change in Condition", dated 11/2016, documents, "immediate notification is recommended for any symptom, sign or apparent discomfort that is acute or sudden in onset and is a marked change in relation to usual symptoms and signs, or is unrelieved by measures already prescribed." R1's: "Routine Physician Orders/MARs [Medication Administration Record]", dated 1/1/2017, documents, "Advanced Directives: Full-Code"; "Admission Record Report", dated 1/1/2017, documents, "Current admission date-12/26/2016"; "Radiology Report", dated 1/1/2017, documents, "Patchy perihilar infiltrates and subsegmental atelectasis with minimal right pleural effusion"; and Physician's Order Form, dated 1/1/2017, documents, levofloxicin 750 milligrams daily, times five days, for Upper Respiratory Infection. R1's vital signs are documented in the electronic medical record as blood pressure-115/26, heart rate-89 and respiratory rate-20 on 1-2-17 at 10:55 AM. R1's vital signs are documented in the electronic medical record as blood pressure-143/67, heart rate-83 and respiratory rate-24 on 1-2-17 at 8:30 PM. R1's "[Facility initials/city] Progress Notes", dated 1/3/2017, at 11:17 a.m., document, "Cont[inues] to have increased SOB [shortness of breath], at	F 309		

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F 309	Continued From page 10 rest and esp[ecially] with any exertions. O2 [oxygen] is running at 3 L [liters] per nasal cannula, and sat[uration] is just at 89%. Up to 4L with no improvement. Remains on [levofloxicin] for pneumonia..." R1's medical record does not document R1's physician was notified, nor any new orders prescribed. R1's medical record does not provide any further documentation until 1/3/2017 at 5:20 p.m. R1's "[Facility initials/city] Progress Notes", dated 1/3/2017, charted by E3 (Licensed Practical Nurse), document: 1) "1720 [5:20 p.m.] VS [vital signs] were taken MD [medical doctor] was called for new order for nebs [breathing treatments]. BP [blood pressure] 98/42, P [pulse] 96, R [respirations] 22, T [temperature] 98.6. Resident was alert and responding could not tell me what was wrong with her she kept saying I don't know"; 2) "1745 [5:45 p.m.] this nurse reentered room to check on the resident and there were 0 respirations, skin cool no VS or heart tones"; R1's medical records do not provide documentation that vitals, or status checks, were done on R1, from 5:20 p.m. to 5:45 p.m. on 1/3/2017. On 1/5/2017, at 12:44 p.m., E3 confirmed: E3's nursing progress notes; and confirmed no resident status checks were done from 5:20 p.m. to 5:45 p.m. on 1/3/2017. On 1/5/2017, at 12:00 p.m., E2(Director of Nursing) confirmed: R1 was admitted on 12/26/2016 from a local hospital; R1 was to be a short-term stay and then be discharged to R1's home; R1 was a full-code status upon admission; and no resident status checks were done from 5:20 p.m. to 5:45 p.m. on 1/3/2017.	F 309		

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F 309	Continued From page 11 On 1/5/2017, at 3:30 p.m., R2 [R1's roommate on 1/3/2017], stated, in between R1's vitals being taken [at 5:20 p.m.] and staff coming back in the room [at 5:45 p.m.], all R2 heard was noises and " I knew she needed help". R2 was unable to give a timeframe for when R2 last heard any noise from R1's side of the room. The facility document, entitled "Record of Death", documents R1's "Date of Death: 1/3/2017 and Hour: 5:45 p.m."	F 309		