STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6004121	A. BUILDING: _____ B. WING _____	C 03/20/2019

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HEARTLAND NURSING & REHAB	410 NORTHWEST THIRD CASEY, IL 62420

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S 000	Initial Comments Facility Reported Incident to Incident of 3/16/19/IL110440	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 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. 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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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:
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. (Section 2-107 of the Act)

These requirements were not met evidencded by:

Based on record review, and interview, the facility failed to supervise two residents (R1 and R2) while on a toilet / bedside commode. These failures resulted in R1 falling and sustaining a Left Hip Fracture. R1 and R2 are two of six residents reviewed for falls in the sample of six.

Findings include:

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1. R1's Face Sheet documents R1 was admitted to the facility 6/16/17. (R1 is currently hospitalized)

R1's Physician Order Sheet (POS) dated March 2019 documents the following diagnoses: Unspecified Dementia, Brief Psychotic Disorder, Major Depression, Tinnitus (ringing in the ears), and Insomnia.

R1's Medication Administration Record dated March 15, 2019 at 8:00 pm (four and a half hours prior to fall 3/16/19 at 12:30 am) documents R1 received the following medications: Melatonin 5 milligrams (mg), Mirtazapine 15 mg and, Cannabidiol drops Full Spectrum 3 drops.

R1's Minimum Data Set (MDS) dated 12/13/18 documents the following: Moderate Cognitive Impaired - decisions poor; cues and supervision required. The same MDS documents R1 is not able to stabilize without staff assistance to move on or off toilet, stand from seated position, and requires extensive staff assistance with transfers and ambulation.

R1's Care Plan dated 12/14/18 documents the following: "I have a high risk for falls. I will have no injury from falls from 12/19/18 - 3/19/19."

R1's "Fall Risk Evaluation" dated 12/13/18 documents a total score of 14, with a score greater than 10 representing "High Risk." The same Fall Risk Evaluation documents R1 has had three or more falls in the last three months.

A facility report titled "Incident Log" dated November 2018 through March 2019 documents R1 fell on 11/25/18, 12/24/18, 12/30/18, 1/3/19, 1/15/19, 1/31/19, 2/28/19 and 3/16/19.

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S9999	Continued From page 3 R1's "Fall Management - Post Fall Assessment Tool (included Resident Incident Reports)" document R1 has had falls on the following dates: 11/25/18, 12/24/18, 12/30/18, 1/3/19, 1/15/19, 1/31/19, 2/28/19 and 3/16/19. All the above-mentioned falls "Fall Management - Post Fall Assessment Tool (Resident Incident Reports)" reports document the investigation were completed and R1 sustained no major injuries, until 3/16/19 fall with left hip fracture. R1's "Resident Incident Reports" dated 3/16/19 at 12:30 am documents by V3, Registered Nurse / RN and V6, Licensed Practical Nurse / Fall Investigator as follows: R1 fell in the bathroom. V3 observed the fall. R1's Resident Incident Report included an attached statement written by V3. The attached statement documents the following: "I (V3) pottied (taken to the toilet) (R1). While she (R1) was on the toilet (R2), across the hall, was on the commode and stood up to transfer herself (R2). I (V3) was torn between the two residents. (R1 was sitting (on the toilet), not fidgeting so I hurried across the hall and sat (R2) on (R2's) bed. As I was returning to (R1's) room I witnessed (R1) falling to her left side. I couldn't be in both places at the same time. (V4, Certified Nursing Assistant / CNA) was on the north hall at the time. (R1) did not hit her head. (R1) fell mainly on her left arm. (R1) did not complain of pain. (V4, CNA) and I put her (R1) to bed and her (R1) fell asleep and didn't to stir the rest of the night while I was there (working till 3:00 am)." R1's Nurse Progress Note dated 3/16/19 at 7:24 am, signed by V2, Director of Nursing / DON documents the following: "Resident (R1) rested quietly until this time. (V9, CNA) CAN started to get her (R1) up and ready for the morning and	S9999		

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when (V9) CAN went to swing resident's legs over to the side of the bed the resident (R1) moaned and yelled out 'that hurts'. (V9) called for nurse (V2, DON) to come to the room. During assessment resident (R1) complained of left thigh / knee pain when the (R1's) leg was palpated. Resident (R1) would not flatten her legs to check for rotation or shortening. Resident (R1) is unable to flatten her legs normally. When (R1's) arms were palpated resident complained of pain as well. Whenever resident (R1) was touched she would say it hurt and then make comments that didn't make sense like 'it came down the straw'. The (R1's) left knee area was warmer to touch than the right (knee). No redness, swelling or bruising noted. (V10) paged at 7:25 am. (V17, R1's Family Member) notified of incident and does want an X-Ray done. Resident (R1) remains in bed currently. Personal alarm and floor alarm on. Call light within reach." R1's Nurse Progress Note dated 3/16/19 at 8:21am documents V8 Physician was on call for V10, Physician and gave orders for R1 to be sent to the emergency room for evaluation and treatment.

R1's Hospital Diagnostic Radiology Report (X-Ray) dated 3/16/19 at 11:01 am, documents the following: "X- Ray Hip 2 or Greater Views Left and Pelvis. Findings: Diffuse Osteopenia. Mild degenerative changes to both hips. Mildly displaced left intertrochanteric femur fracture (hip fracture)."

R1's Hospital "Emergency Documentation" dated 3/16/19 documents the following: "Emergency Department Course; discussed with the patient (R1) that she does have a hip fracture. She (R1) is going to require hospitalization and orthopedic surgical treatment."

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S9999	Continued From page 5 2. R2's POS dated March 2019 document the following Diagnoses: Anxiety, Pain, Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, Atherosclerotic Heart Disease of Native Coronary Artery, Pulmonary Fibrosis and Gout. R2's Fall Risk Evaluation dated 12/29/18 documents R2 is at high risk for falls, score 16. Total score of ten or above represents high risk. R2's "Resident Incident Report dated 9/23/18 documents R2 self-transferred while going to the bathroom. R2's Care Plan updated 1/17/19 documents the following: "I (R2) have weakness with unsteady on feet. I become anxious when I have difficulty breathing due to COPD. Assist with transfers and toileting. I have a risk for falls, as evidenced by impaired balance during transitions. Fell in room 1/7/18, 1/17/18, 1/22/18 fell responding to bladder needs, 3/14/18 slid out of wheelchair, 3/26/18 fell in room, 4/18/18 fell in room, 4/19/18 fell in room, 4/29/18 observed fall in hallway, 7/16/18 hallucinating and wheel chair brakes not locked, 7/29/18 up without assist and fell, 9/23/18 left alone in bathroom by CAN (unidentified). The same care plan documents the following fall prevention interventions:" seat alarm, bed alarm, and motion sensor floor alarm, and educate staff to never leave resident alone in bathroom." R2's Minimum Data Set dated 12/27/18 documents R2 has severe cognitive impairment, requires limited physical staff assistance with transfer, extensive staff assistance with toileting, and cannot steady herself without staff assistance walking, transferring, toileting, or moving from seated to standing position.	S9999		

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S9999	Continued From page 6 On 3/19/19 at 2:40 pm V3 stated the following: "We have four halls with about fifty residents all together. We only have one nurse and usually two CNA's at night, sometimes three. Most of the time that is enough on nights. The night (R1) fell and broke her hip, the CNA's were both busy working down other halls. We had all been trying to encourage (R1) to let us get her ready for bed. (R1) finally agreed. I was taking (R1) to the bathroom when (R2) put on her call light. I transferred (R2) to (R2's) bedside commode and clipped (R2's) personal alarm on her shirt. I then went back across the hall (leaving R2 unsupervised) and transferred (R1) to the toilet. (R2's) alarm went off so I knew she wanted off the bedside commode. Both (R1 and R2) are high risk for falls so I went immediately to assist (R2) (leaving R1 unsupervised). As soon as I got (R2) to the side of the bed, I could see across the hall that (R1) was getting off the toilet by herself. I watched R1 fall to the floor. I left (R2) sitting on the side of the bed (unsupervised). I forgot to put her personal alarm back on (R2's Care Plan intervention). I was torn between the two residents both (R1 and R2 are) at high risk for falls with history of falls. (R1) had stood up from the toilet so I hurried to her but did not get there soon enough to prevent her fall (with left hip fracture). (R1) did not hit her head. I should not have left her on the toilet alone. Hind sight is 20 - 20. I should have finished toileting (R2) before putting (R1) on the toilet. I assessed (R1) and (R1) was bleeding from two skin tears on her left arm. (R1) did not complain of pain when I checked her legs. (R1) did not show any signs of rotation or discoloration to her hip. I transferred (R1) back onto the toilet and put on the call light. (V4, Certified Nursing Assistant) responded and stayed with (R1) while I went to get supplies to dress (R1's) skin tears. I left (R1's) room and	S9999		

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went back to (R2's) room. I lifted (R2's) legs back into bed and put (R2's) personal alarm back on. I should not have left her (R2) unattended either and should have made sure her alarm was on when I had to leave her to help (R1). I am so glad (R2) didn't fall too. I was so torn between who to help. I got the dressing supplies, cleaned and dressed (R1's) skin tears. (V4) and I (V3) put (R1) in bed. (R1) did not complain of pain. (R1) slept the rest of my shift (until 3:00 am)."

On 3/19/19 at 3:00 pm V2, Director of Nursing (DON) stated the following: "I came in at 3:00 am on 3/16/19, the night (R1) had her fall, that resulted in the hip fracture. (R1) was asleep when I came in and continued to sleep without signs of restlessness or discomfort. Around 7:00 am (V9, Certified Nursing Assistant) CNA was getting her (R1) up for breakfast. (R1) complained of left knee and thigh pain so (V9, CNA) left (R1) in bed and reported to me (V2, DON). I (V2, DON) assessed (R1), who could not flatten her legs to assess for shortening or rotation. (R1) continued to complain of pain in (R1's) left leg, left knee and left arm when I palpated these areas. The doctor's office was called (V10's, R1's Physician). (V8, Physician) was on call for (V10, R1's Physician) and called back with order to send (R1) out to the hospital for X-Rays). R1 was admitted to hospital with a left hip fracture. I expect all staff to stay with residents when toileting. This should not have happened. (R1) should not have been left on the toilet. R2 should not have been left on the bedside commode. (V3, Licensed Practical Nurse) should have completed (R2's) care before starting (R1's) care. (R2) should have been put back to bed and (R2's) alarm should have been on before (V3, LPN) initiated (R1's) care. This would have most likely prevented (R1's) fall that night."

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On 3/20/19 at 10:20 am V10, Primary Care Physician stated the following: "(R1's) left hip fracture was caused by the fall (3/16/19). I was not informed that (R1) was left unattended on the toilet. The fall likely could have been prevented if (R1) was not left by herself. (V8, Physician) was on call Saturday and sent (R1) to the hospital as soon as he was informed of the pain post that fall."

The facility "Fall Prevention and Management Policy and Procedure" dated January 8, 2017 documents the following: "Each resident must be assessed on admission, quarterly and any changes in condition for potential risk for falls to take preventative approach. Discussions regarding the acceptable level of risk must be based on individual assessment with input from resident and/or resident's representative and interdisciplinary team. Purpose: 3. Provide appropriate strategies and interventions directed to resident environmental factors and staff.

The facility policy "Safety and supervision of Residents" dated July 2017 documents the following: "Our facility strives to make the environment as free from accidents hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility- wide priorities." The same policy documents: "Individualized, Resident -Centered Approach to Safety, 3. The care team shall target interventions to reduce individual risk related to hazards in the environment, including adequate supervision and assistive devices."

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