STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000293	A. BUILDING: _____ B. WING _____	C 06/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF PEORIA	5600 GLEN ELM DRIVE PEORIA, IL 61614

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S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1830a) 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 300.1830 Records Pertaining to Residents' Property a) The facility shall maintain a record of any resident's belongings, including money, valuables and personal property, accepted by the facility for safekeeping. This record shall be initiated at the time of admission and shall be updated on an ongoing basis and made part of the resident's record.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 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 are not met as evidenced by: Based on record review, interview and observation, the facility failed to provide and document sufficient preparation and resident orientation in order to ensure safe and orderly discharge from facility and failed to return personal belongings, cell phone and home keys upon discharge, for one of three residents (R1) reviewed for discharge planning in the sample of three. This failure resulted in R1 spending the night on his porch during 90 degree Fahrenheit temperatures. Subsequently R1was hospitalized for edema after being sunburned and sitting in feces overnight. Findings include: The facility's "Discharge: Home or Non-Institutional Setting" policy, dated December 2009, states that the purpose of this policy is: "To provide safe departure from center to home or non-institutional setting." This policy includes, under "Procedure: Day of Discharge to Home or Non-Institutional Setting" to "Complete discharge summary paperwork and place into medical record".	S9999		

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S9999	Continued From page 2 R1's clinical record includes diagnoses of : Schizophrenia, History of Colitis with bowel incontinence and Hypertension. R1's BIMS (Brief Interview for Mental Status) score, dated 6/6/17, indicating R1 has minimal cognitive impairment. R1's electronic clinical record includes an interdisciplinary, discharge instruction document, titled "My Transition Home 1", dated 6/12/17. This document includes numerous blank sections, including: "Discharge Information", "Patient/Resident Representative Education" and "Discharge Instructions" from Nursing, Therapy and Social Services. The "Medication" section is also blank, including the sub-sections titled, "Medication I Will Be Taking When I Go Home", "Instructions", and "Discharge Medication Education". On 6/21/17 at 2:00p.m., E8, RN stated that she was R1's nurse on 6/14/17 and received report that R1 was discharging, via facility van, to home around 3:00p.m. that day. "The transport guy said he was leaving in a few minutes around change of shift." When asked about the discharge instructions for R1, E8 stated, "We do some of those, but the ward clerk usually does them." On 6/22/17 at 9:00a.m., E3, ADON (Assistant Director of Nursing) stated, "My Transition Home is the discharge instruction packet for residents, with instructions regarding equipment needed, medications, appointments." E3 stated that R1's discharge instruction packet was not completed prior to discharging R1 home on 6/14/17. E3 verified that R1's discharge instructions and education by Nursing, Social Services and Therapy were blank and should have been completed for R1 prior to R1's discharge home.	S9999		

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R1's electronic clinical record includes a Progress Note by E8, RN (Registered Nurse), dated 6/14/17 at 3:15p.m. stating, "Patient discharged to home with belongings. Transported per facility van."

On 6/20/17 at 11:00a.m., E6, facility Chauffeur, stated that on 6/14/17, at approximately 3:15p.m., R1 was discharged from the facility to his home and transported, via the facility van, by E6, Chauffeur and E7, Chauffeur trainee. E6 stated that R1 had discharge papers from the facility in his possession upon discharge from the facility. Upon arrival at R1's house, E6 stated he and R1 checked the front and back doors and discovered both doors were locked. E6 verified that R1 told E6 and E7 that R1 did not have his house keys. E6 stated that he and E7 left R1's house to return to the facility and last saw R1 sitting in his back yard at approximately 3:45p.m. on 6/14/17.

On 6/21/17 at 10:35 a.m., E7, Chauffeur trainee, verified that on 6/14/17, E6 and E7 transported R1 to R1's house "around 3 or 4 o'clock". E7 stated that when they arrived at R1's house, the doors were locked and there was no response to knocking. E7 added that R1 told the Chauffeurs that R1 had "lost his keys".

On 6/21/17 at 8:45a.m., E6, Chauffeur, stated that Z1 (Caregiver), called the facility on 6/15/17 and asked E6 if R1's keys and cell phone were at the facility. E6 stated, "I took a note and wrote it down and called the Nurses Station. I don't think they ever got found. Nothing ever came of it."

On 6/20/17 at 1:10p.m., E9, LPN (Licensed Practical Nurse), stated that R1's cell phone and personal keys were present in the medication cart's locked narcotic box for "a number of days"

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prior to R1's discharge from the facility. E9 stated these items were accounted for upon narcotic reconciliation at each change of shift.

Z1's local hospital ER (Emergency Room) record, dated 6/16/17 at 1:22p.m., by Z6, RN, documents that R1 was transported to the hospital via ambulance on 6/16/17 and arrived at 1:22p.m. on 6/16/17 for "lower extremity swelling". An ER nursing note by Z8, RN states: "Patient was discharged from (facility) on 6/14 and spent the night on his porch because he lost his keys and phone there. Caregiver came 6/15 and called a locksmith and he was able to get into his house. Today when caregiver went back, he had a lot of swelling in his feet. He has a sunburn on his legs arms and hands from spending all that time on his porch. Patient states he has no family. Patient's jeans covered in feces. Patient hasn't eaten today "because I forgot."

The National Weather Service, on 6/15/17, had a high temperature of 90 degrees Fahrenheit on 6/14/17 in the town in which R1's house is located.

R1's ER "Chief Complaint note, dated 6/16/17 at 3:52p.m., by Z7, R1's ER doctor, documents the following: "Patient presents with Foot Swelling. The history is provided by the patient. (R1), with history of HTN (hypertension), who presents to the ED (Emergency Department) via (local ambulance)for the evaluation of bilateral, lower extremity swelling that began two weeks ago. The leg swelling is unchanged today."

R1's local hospital inpatient record documents that R1 was admitted to the hospital on 6/17/17 after a 23-hour in-house observation period in the ER.

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On 6/21/17 at 11:00a.m., R1 was sitting up in bed in his room at a local hospital. R1 was alert and appropriate, with lightly tanned skin on face and extremities. R1 stated that he was discharged from (facility) on June 14, 2017, "Two men took me home in the (facility) van." R1 stated that the van drivers walked him to the front and back doors and both doors were locked. "I had no keys. I just sat down on the cement in the back of my house and they left." When asked how and when he gained access to his home, R1 said he waited for (his caregiver, Z1) to arrive and slept on his porch overnight, "I got a little sunburned on my arms and legs." R1 stated his caregiver arrived the next morning, 6/15/17 and called a locksmith to open the door to his home. R1 stated that he had his cell phone and house keys with him when he was admitted to the facility and, "I didn't have my cell phone or house keys when they took me home." When asked how long he was locked outside of his house, R1 replied, "24 hours." R1 recalled that his house keys and cell phone had been brought in to him earlier that morning, stating "A man from (facility) brought them to me this morning. I think they were in the nurses station."

On 6/21/17 1:30pm, E1, Administrator, stated that R1's cell phone and house keys were located in the narcotic box in the facility's medication cart and he delivered them to R1 at the hospital earlier that morning.

On 6/23/17 at 11:40a.m., E1, Administrator, stated that residents usually go home with belongings and a discharge "booklet". E1 verified that R1's discharge instructions were incomplete.

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