

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006233	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2021
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTLAND OF MOLINE	STREET ADDRESS, CITY, STATE, ZIP CODE 833 SIXTEENTH AVENUE MOLINE, IL 61265
----------------------------------------------------------------	-------------------------------------------------------------------------------------------

(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 CORRECT ION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments	S 000		
	Annual Licensure and Recertification			
S9999	<p>Final Observations</p> <p>Statement of Licensure Violation:</p> <p>300.1210b) 300.1210d)3) 300.1210d)6)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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.</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>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>6) All necessary precautions shall be taken to assure that the residents' environment remains</p>	S9999	<p style="text-align: center;">Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---------------------------------------------------------------------------------------------------------------	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006233	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2021
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTLAND OF MOLINE	STREET ADDRESS, CITY, STATE, ZIP CODE 833 SIXTEENTH AVENUE MOLINE, IL 61265
----------------------------------------------------------------	-------------------------------------------------------------------------------------------

(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) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

S9999	<p>Continued From page 1</p> <p>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>Based on observation, interview, and record review, the facility failed to provide thickened liquids as ordered by a physician for one of five residents (R63) reviewed for nutrition in the sample of 40. This failure resulted in R63 being admitted to the hospital with aspiration pneumonia.</p> <p>Findings include:</p> <p>R63's care plan, dated 5/12/21, documents, "Problem: Eating and Swallowing. Goal: Will improve eating and swallowing as evidenced by safely consuming the least restrictive diet possible with minimal to no signs and symptoms of aspiration. Interventions: Bedside Swallow Evaluation; Swallowing Treatment.</p> <p>R63's Order Audit Report, dated 6/9/21, documents that R 63 received an order to receive Mildly Thick (nectar) consistency liquids on 6/3/21.</p> <p>63's Speech Therapy Treatment Encounter Note, dated 6/3/21, documents, "Skilled interventions addressing Swallow Dysfunction included Diet texture analysis to increase safe oral intake. Liquid swallows to increase safe oral intake, techniques to improve safe and efficient nutrition/hydration and therapeutic trial feedings to increase safety. Response to session interventions: R 63 displayed a consistent delayed, weak cough after drinking thin ice water per cup. Trials of mildly thick liquids were consumed without signs/symptoms of aspiration</p>	S9999		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006233	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2021
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTLAND OF MOLINE	STREET ADDRESS, CITY, STATE, ZIP CODE 833 SIXTEENTH AVENUE MOLINE, IL 61265
----------------------------------------------------------------	-------------------------------------------------------------------------------------------

(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) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>initially. 63's speech became slurred during session and nursing was alerted. Nursing assessed patient and speech improved during that time. R 63 was given additional trials of mildly thick liquids and displayed a delayed cough after presentations. Trials of moderately thick juice and yogurt were tolerated without signs/symptoms of aspiration. Recommend downgrade to puree with moderately thick liquids at this time."</p> <p>On 06/07/21 at 12:29 PM, R 63 was alert sitting up in his wheelchair in his room. R 63 had a bedside table in front of him with his lunch of pureed beef stew, pureed green beans, pudding, and a 7-ounce glass of a clear thin liquid. R 63 stated, "I just don't want to eat. I'm fine with just this cold glass of water," pointing to the water cup that was half empty.</p> <p>On 06/07/21 at 12:35 PM, V 9 (Registered Nurse) stated that R 63 is on thickened liquids, and that there shouldn't be any on his table. V 9 entered 63's room and confirmed the half drank glass of water was not thickened.</p> <p>63's Respiratory Note dated 6/8/2021 13:12, documents, "Presence of cough: Yes. Lung sounds; Right Upper Lobe Diminished, Right Lower Lobe Crackles, Left Upper Lobe Diminished, Left Lower Lobe Crackles."</p> <p>63's Nurses' note, dated 6/8/2021 at 16:01, "Spoke to wife about 63's change in condition. R 63 is ashen in color and unable to concentrate on conversations. Appears agitated and uncomfortable. Wife stated she would like R 63 to be sent out to be evaluated and treated at the ED (Emergency Department)."</p> <p>63's Nurses' note dated 6/8/2021 at 18:06,</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006233	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2021
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTLAND OF MOLINE	STREET ADDRESS, CITY, STATE, ZIP CODE 833 SIXTEENTH AVENUE MOLINE, IL 61265
----------------------------------------------------------------	-------------------------------------------------------------------------------------------

(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) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>document, "R 63 Temperature 101.4 degrees Fahrenheit, cold towels applied to head and back of neck. Moaning skin hot and dry, color poor, lungs upper diminished, lower crackles, coughing moist sounding. Pulse oximetry 79% room air, oxygen started at 1 1/2 liters. Called for ambulance. 63's temperature 99.9. Still not responding to verbal stimuli, finger cool unable to get pulse oximetry reading. Ambulance here with team to take at 5:25 PM out of facility."</p> <p>63's Emergency Department (ED) Chief Complaint and History of Present Illness, dated 6/8/21, documents, "R 63 is a 78 year old male presenting the ED by ambulance for fever." Also, documents, "Physical Exam: Pulmonary: Effort: Achy (rapid respirations) and respiratory distress present. Comments: Coarse breath sounds bilaterally." The Chief Complaint and History of Present Illness documents, "Progress notes: Spoke with wife, son, and daughter. I discussed code status with spouse and family. I explained that R 63 is critically ill with sepsis and probably aspiration pneumonia. Prognosis is extremely poor. Wife and family indicated that R 63 would not want any form of invasive life support. I discussed with them at length the treatment options. Wife and family request comfort measures only and DNR (Do Not Resuscitate) status."</p> <p>On 06/09/21 at 10:53 AM V 5, RN (Registered Nurse) stated, "I cared for (R 63) yesterday, he had a moist crackled cough and had crackles in his bilateral lower lobes. The cough would come and go at times, but the crackles were new. (R 63) has difficulty swallowing and was just downgraded to thickened liquids a few days ago."</p> <p>On 06/09/21 at 11:22 AM, V 10 (Speech</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006233	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/10/2021
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER HEARTLAND OF MOLINE	STREET ADDRESS, CITY, STATE, ZIP CODE 833 SIXTEENTH AVENUE MOLINE, IL 61265
----------------------------------------------------------------	-------------------------------------------------------------------------------------------

(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) COMPLETE DATE
S9999	<p>Continued From page 4</p> <p>Therapist) stated, "I was working with (R 63) for cognitive deficit and dysphasia (difficulty swallowing). (R 63) seemed more confused that day (6/3/21) I saw him. He had a consistent delayed weak cough with thin liquids. The delayed cough is a sign that liquids are penetrating the wrong area or aspiration. He would take a drink and a few seconds later he would have a weak cough. I knew something was going on. I tried the mildly thick liquids (nectar) and he did well. Then all of a sudden, his speech was slurred. I immediately notified staff and during their assessment he started to come back around. So I tried the mildly thick liquids again, and he started the delayed cough again. So I tried moderately thick liquids (honey) and he did much better. So I ordered for him to have pureed and moderately thicken liquids. He should be monitored for lung sounds changing, temperature, and intake. These would be signs of him not tolerating the diet and aspiration. If he was drinking thin water on his own it could develop into pneumonia over time."</p> <p>(A)</p>	S9999		