STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145016	A. BUILDING _____ B. WING _____	C 12/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-BLOOMINGTON	700 EAST WALNUT BLOOMINGTON, IL 61701

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F 000	INITIAL COMMENTS Complaint Investigation 2169440/IL141542-F689, F655 Investigation of Facility Reported Incident of 12/12/21/IL141633- F689 Investigation of Facility Reported Incident of 12/13/21/IL141653- F689	F 000		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655	**Attachment A** **Statement of Licensure Violations**	1/13/22

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

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 655	Continued From page 1 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide a baseline care plan summary to residents' representatives. This failure affects four residents (R1, R2, R4, and R7) out of four reviewed for baseline care plans on the sample of seven. Findings include: The facility's Care Plan Policy, dated 11/2017, documents, "The baseline care plan will be completed and implemented within 48 hours of admission, and a summary of the baseline care plan will be provided to the resident and responsible party by the completion date of the comprehensive care plan." "Before the completion of the comprehensive care plan, the care plan coordinator, or his/ her designee, shall make contact with the resident and responsible party (if applicable) to review care needs as indicated on the baseline plan of care."	F 655		

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F 655	Continued From page 2 1. R1's Census Detail (undated) documents R1 was admitted to the facility on 12/31/20. R1's Electronic Medical Record did not document provision of R1's baseline care plan to R1's Power of Attorney (V14). R1's Face Sheet (undated) documents V14, Family Member of R1, is R1's Healthcare Power of Attorney, and V19, Family Member, is R1's Financial Power of Attorney. On 12/22/21 at 3:41 pm, V14, Family Member/ Healthcare Power of Attorney for R1, stated, "They (facility staff) did not provide me nor my sister (V19, Family Member/ Financial Power of Attorney for R1) with a written care plan. They did finally have an in-person meeting on 1/28/21 but that was discussing (R1's) discharge scheduled for 2/5/21 to arrange equipment and home care that would be needed at home." 2. On 12/22/21 at 2:30 pm, V8, Spouse/ Power of Attorney for R2, stated, "No one gave me anything written about (R2's) care plan, in fact they never even had a meeting about it until I requested it, and they did that today." R2's Electronic Medical Record did not document any provision of R2's baseline care plan provided to V8, Spouse/ Power of Attorney for R2. R2's Census Detail (undated) documents R2 was admitted to the facility 11/12/21. R2's Face Sheet (undated) documents V8, Spouse of R2, is R2's full and sole Power of Attorney. 3. On 12/23/21 at 11:16 am, V16, Family Member/ Power of Attorney for both R4 and R7, stated, "No, no one from the nursing home has given me a written care plan for (R4) or (R7). I	F 655		

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F 655	Continued From page 3 know my brother (unnamed) has had to fill out some paperwork with the social service people, but as far as a giving us a care plan or sitting down and even talking about a care plan, no." R4's and R7's Electronic Medical Record did not include documentation that a summary of R4's and R7's baseline care plan was provided to V16. R4's Census Detail (undated) documents R4 was admitted to the facility 11/22/21. R7's Census Detail (undated) documents R7 was admitted to the facility 11/4/21. R4's and R7's Face Sheet (undated) documents V16 is R4's and R7's Healthcare Power of Attorney. On 12/23/21 at 3:31 pm, V1, Administrator, stated, "We really need to tighten up that process."	F 655		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to initiate new fall prevention interventions in response to falls, and failed to implement existing interventions to prevent falls. These failures affect two residents (R2 and R3) out of three reviewed for falls on the sample of seven. These failures resulted in R2 experiencing an	F 689		1/13/22

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F 689	Continued From page 4	F 689		

intraparenchymal hemorrhage (brain bleed) which required an 8-day hospital stay to resolve, and R3 experiencing a fractured right clavicle and 9 sutures in the forehead.

Findings include:

1. R2's Electronic Medical Record documents R2 was admitted to the facility 11/12/21, with Medical Diagnoses including Cerebral Infarction (Stroke), Muscle Weakness, Lack of Coordination, Difficulty Walking, Muscle Wasting and Atrophy, Loss of Vision of Left Eye, Non-Ruptured Cerebral Aneurysm, Non-Traumatic Cerebral Hemorrhage (Resolved), and Monoplegia (weakness) of Right Upper Limb.

R2's Census Detail (undated) documents R2 was in the hospital from 12/12/21 through 12/20/21, and re-admitted to the facility 12/20/21.

R2's Nurses Notes, dated 12/9/21, document R2 experienced a fall from a wheelchair on 12/9/21 at 9:30 am. This same Nurses Note documents R2 was complaining of right shoulder pain after this fall and received an x-ray of the right shoulder.

R2's Care Plan for fall prevention documents a simple narrative statement, dated 12/9/21, "I had a fall from my wheelchair this morning, I was leaning forward (due to) abdominal discomfort, I overextended my lean and fell forward." This Care Plan did not include a new intervention in response to this fall to prevent further falls nor to ensure R2's safety in the event of further falls.

R2's Nurses Notes, dated 12/12/21, document R2 experienced another fall from the recliner on

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F 689	Continued From page 5	F 689		

12/12/21 "around 11:30 (am)" when R2 was observed by facility staff lying on the floor on (R2's) face. This same Nurses Note documents R2 was sent to the emergency room after a neurological check at the facility.

R2's Emergency Department Notes, dated 12/12/21, document R2 experienced acute bruising (ecchymosis) around the right temple, and an acute Right Side Traumatic Intraparenchymal Hemorrhage (brain bleed). These same Emergency Department Notes document R2 admitted to the hospital for treatment of this new brain bleed.

On 12/23/21 at 11:30 am, V1 Administrator, V2, Director of Nursing, and V17, Regional Clinical Director, all declined to answer if they thought the simple narrative statement documented in R2's Care Plan for the fall on 12/9/21 constituted an intervention, without first reviewing R2's record. At 2:18 pm, V2, Director of Nursing, stated, "We knew (R2) was leaning forward to relieve (R2's) pain so we increased (R2's) pain medication (Tylenol) and it seemed effective. I can't say why it doesn't make it onto the Care Plan."

R2's Medication Administration Record (MAR) for December 2021 documents prior to the fall on 12/9/21, R2 received 3 doses of Acetaminophen (Tylenol) 650 milligrams, one dose on 12/4/21 at 12:33 pm, one dose on 12/8/21 at 4:37 pm, and one dose on 12/9/21 at 1:00 am. This same MAR documents after R2's fall on 12/9/21, R2 received 3 doses of Acetaminophen 650 milligrams, one dose on 12/9/21 at 12:20 pm, one dose on 12/11/21 at 4:27 pm, and one dose on 12/12/21 at 5:33 am.

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F 689	Continued From page 6 On 12/23/21 at 3:31 pm, V2, Director of Nursing, acknowledged R2 did have a sore right shoulder after the fall on 12/9/21, prompting R2's Advanced Practice Nurse (V15) to order an x-ray. 2. R3's Electronic Medical Record documents R3 was admitted to the facility 9/15/21, with medical diagnoses including Muscle Weakness, Unsteadiness on Feet, Muscle Wasting and Atrophy, Syncope and Collapse, and Macular Degeneration. This same Medical Record documents a medical diagnosis of Fracture of Left Clavicle, dated 12/14/21. R3's Nurses Notes, dated 12/3/21, documents R3 experienced a fall on 12/3/21 at 9:50 pm while ambulating to the bathroom. R3's Care Plan for fall prevention documents a simple statement, dated 12/3/21, "I am in the safest environment possible." This Care Plan did not include a new intervention in response to this fall to prevent further falls, nor to ensure R3's safety in the event of further falls. R3's Nurses Notes, dated 12/13/21 documents R3 experienced another fall while ambulating to the bathroom with a staff member, landing prone on the floor and hitting (R3's) forehead on the floor. This same Nurses Note documents R3 was sent to the emergency room for evaluation. R3's Care Plan for fall prevention, dated 12/13/21, documents R3 had fallen because R3 tripped over the phone cord. This same Care Plan documents an existing fall prevention intervention, dated 9/16/21, to "Keep a clear pathway to my bathroom."	F 689		

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F 689	Continued From page 7 R3's Emergency Room Report documents an x-ray of the left shoulder determined R3 had fractured the left clavicle. This Emergency Room Report also documented R3 experienced a right forehead laceration, and bruise of the right knee. The hospital discharge instructions document R3 is to have the sutures removed from the right forehead in approximately 7 days, and to remain non-weight Bearing on the left upper extremity. On 12/23/21 at 11:30 am, V1, Administrator, V2, Director of Nursing, and V17, Regional Clinical Director, all declined to answer if they thought the simple narrative statement documented in R3's Care Plan for the fall on 12/3/21 constituted an intervention, without a review of R3's record. On 12/23/21 at 2:18 pm, V2, Director of Nursing, stated, "I talked to the CNA (Certified Nursing Assistant, unnamed) who walked (R3) to the bathroom and she said the phone was on the overbed table and she moved it to the bedside bureau but there must have been a little bit of the cord left sticking out."	F 689		