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 04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND NURSING & REHAB	410 NORTHWEST THIRD CASEY, IL 62420

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S 000	Initial Comments Complaint Investigation 2262892/IL145753	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210 b)5) 300.1210d)6) 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 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.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. 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. These requirements are not met as evidenced by: Based on observation, interview and record review the facility failed to supervise a resident while on the toilet (R1), failed to implement post fall interventions (R2) and failed to lock an unattended treatment cart (R2) for two of three residents (R1, R2) reviewed for falls in the sample list of three. This failure resulted in R1 falling and sustaining a 3 cm (centimeter) laceration and receiving 5 stitches in the Emergency Room. Findings include: The facility's Falls and Fall Risk, Managing policy with a revised date of March 2018 documents, "Policy Statement Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific	S9999		

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S9999	Continued From page 2 risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." "Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls." "5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant." "Monitoring Subsequent Falls and Fall Risk" "4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls." 1.) R1's Minimum Data Set (MDS) dated 2/23/22 documents diagnoses including Parkinson's Disease, Alzheimer's Disease, Non-Alzheimer's Dementia, Anxiety, Depression and Unspecified Dementia with Behavioral Disturbances. This MDS documents R1 has moderately impaired cognitive skills. This MDS documents R1 requires extensive assistance (weight bearing support) of one person for transfers and toilet use and documents R1 is not steady, only able to stabilize with staff assistance, when moving from a seated to standing position and moving on and off the toilet. R1's Care Plan dated 2/27/22 documents to assist R1 with transfers and ambulation, to observe for unsafe actions and intervene and to assist to bathroom or commode as needed. R1's undated active Physician's Orders document orders for Sertraline (antidepressant) 50 mg (milligrams) every day with a start date of 8/13/21, Lorazepam (antianxiety) 0.5 mg twice a day with	S9999		

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S9999	Continued From page 3 a start date of 8/13/21 and Risperidone (antipsychotic) 0.25 mg twice a day with a start date of 9/13/21. The facility's Accident/Incident log documents R1 sustained falls on 2/26/22 (no injury), 4/10/22 (no injury) and 4/11/22 (deep laceration). R1's Incident Report printed on 4/18/22 documents on 4/11/22 at 4:50 AM, CNA (Certified Nursing Assistant) V7 sat R1 on the toilet and turned around to get R1's clothing and R1 fell off of the toilet seat and onto the floor. This report documents R1 sustained a deep laceration approximately 4 cm (centimeters) long to the right forehead and a ragged skin tear 3 cm long to the back of the right wrist. This report documents R1 was sent to the hospital emergency room for treatment. The investigation of the incident completed by V2 Director of Nursing documents the root cause of the fall was that V7 turned around instead of staying focused on R1. R1's emergency room documentation dated 4/11/22 documents, "(R1) with h/o (history of) dementia brought from nursing home after (R1) fell off the toilet commode and hit right forehead causing laceration." Emergency room Procedure Notes document, "Wound Length: 3 cm", number of sutures, "5". R1's undated Resident Care Summary documents R1 is a two person assist, is confused and is incontinent of bowel and bladder. On 4/19/22 at 12:55 PM, V6 CNA stated they refer to the Resident Care booklet if they have questions on how to care for residents. At this time, V4 Restorative CNA stated that V4 is responsible for updating resident information in this booklet and CNAs are to look in the booklet for guidance on resident care.	S9999		

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S9999	Continued From page 4 On 4/19/22 at 12:35 PM, V2 Director of Nursing confirmed regarding R1's fall on 4/11/22 that V7 got distracted after placing R1 on the toilet. V2 stated, "preferably eyes should be on (R1) the whole time." On 4/19/22 at 2:27 PM, V11 R1's Physician stated R1's laceration was caused by falling from the toilet and hitting R1's head. 2.) R2's MDS dated 3/2/22 documents diagnoses including Atrial Fibrillation, Heart Failure, Alzheimer's, non-Alzheimer's Dementia, Seizure Disorder, Anxiety, Depression, Psychotic Disorder and Restlessness and Agitation. This MDS documents a BIMS (Brief Interview for Mental Status) score of 3/15 which indicates severe cognitive impairment. This MDS documents R2 requires limited assistance of one person for transfers and extensive assistance of one person for toileting. This MDS documents R2's balance is not steady when moving from a seated position to standing, moving on and off the toilet and walking. R2 is only able to stabilize with staff assistance. R2's Care Plan dated 8/9/21 documents R2 is at high risk for falls with a start date of 3/24/20 and interventions listed are anti-lock brakes on wheelchair dated 6/25/20, shoes or slipper socks on at all times dated 8/9/21, assist with transfers and ambulation dated 8/9/21, observe for unsafe actions and intervene dated 8/9/21. This care plan documents a fall on 11/1/21 and an intervention of anti tippers were added to R2's wheelchair. R2's undated active Physician's Orders document orders for Citalopram (antidepressant) 20 mg a	S9999		

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S9999	Continued From page 5 day with a start date of 6/15/19, Phenytoin Sodium Extended (antiseizure) 100 mg capsules, three capsules daily with a start date of 6/3/19, Mirtazapine (antidepressant) 15 mg daily with a start date of 8/21/20, Risperdal (antipsychotic) 0.5 mg twice a day with a start date of 11/30/20 and Lorazepam (antianxiety) 0.5 mg twice a day with a start date of 1/24/20. R2's Incident Report printed on 4/18/22 documents on 3/26/22 at 7:42 AM, R2 stood up at the treatment cart from R2's wheelchair. The cart drawers nor the wheels were locked. R2 lost R2's balance and fell pulling the treatment cart on top of R2. R2 sustained five skin tears to R2's arms and a bruise and bump to R2's forehead and a scrape to the outer knee. R2's Nurse Progress notes document that this incident happed at 7:15 PM on 3/26/22 instead of in the morning. These Nurse's Progress notes document R2 was sent to the hospital and returned to the facility at 11:09 PM and x-rays were negative but R2 had a Urinary Tract Infection. R2's Narrative of Investigation documents the root cause to the fall on 3/26/22 was that R2 went up to the cart and the drawers were not locked and R2 tried to pull R2's self up and this caused the cart to tip and R2 fell, and the cart fell on top of R2. On 4/19/22 at 12:35 PM, V2 confirmed R2 fell because the treatment cart was unlocked. V2 stated the carts should be locked at all times. V2 stated that the treatment cart was left in the hallway unlocked and unattended when R2 pulled it over on R2's self.	S9999		

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S9999	Continued From page 6 3.) R2's Care Plan 11/1/21 documents R2 is to have anti tippers on the wheelchair and an intervention dated 8/9/21 to keep the call light in reach. On 4/18/22 at 11:22 AM, R2 was in R2's bed sleeping. R2's wheelchair was next to R2's bed. There was no anti tippers on R2's wheelchair and R2 did not have a call light plugged into the wall. There was an empty plug where the call light was supposed to be. On 4/18/22 at 1:15 PM, R2 was in the dining room leaning R2's head way back over the back of the wheelchair. R2 had anti roll back brakes on the wheelchair but no anti tippers on the wheelchair. On 4/18/22 at 1:03 PM, V6 Certified Nursing Assistant was taking R2 to the bathroom. V6 confirmed R2 did not have a call light in R2's room and V6 did not know why R2 did not have a call light. On 4/19/22 at 11:38 AM, there is still no call light in R2's room. On 4/19/22 at 12:35 PM, V2 Director of Nursing stated V2 was not aware that R2 did not have a call light. V2 stated that R2 should have a call light. (B)	S9999		