Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006233	A. BUILDING: _____ B. WING _____	C 03/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF MOLINE	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
S 000	Initial Comments Initial complaint investigation 1621138/IL83753	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 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. Restorative measures shall include, at a minimum, the following	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/23/16

Illinois Department of Public Health

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S9999	Continued From page 1 procedures: 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 as evidenced by: Based on observation, interview, and record review, facility personnel failed to supervise the transfer [from the seated position to standing position] of one resident (R1) of two residents, reviewed for falls, in a sample of four residents. This failure resulted in R1 falling and sustaining a valgus impacted left subcapital fracture [left hip fracture], which required surgical intervention - specifically, a closed reduction, percutaneous screw fixation. Findings include: Facility, online, medical documentation, lists R1's diagnoses to include: Parkinson's Disease, Alzheimer's Dementia, and Falls. R1's Minimum Data Set, dated 2/11/2016, documents R1's Brief Interview for Mental Status as 13. R1's "Care	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 2	S9999		

Plan," initiated 11/30/2015, documents R1 is "At risk for falls due to impaired balance/poor coordination, unsteady gait, Parkinson's Disease...," with interventions to include: "Educate resident that [R1] needs to call for assist and not get up unassisted...ALL High observation when awake and unsupervised."

R1's "Progress Notes," dated 2/18/2016, document: at 11:45 a.m., "[R1] fell in room with therapy, therapist [E3/Physical Therapist Assistant] turned [E3's] back to get something and [R1] attempted to transfer self to chair. [R1] fell on left side, skin tear x 2 to left elbow. Areas cleaned and dressed, Left hip assessed [by E4/Registered Nurse], ROM [range of motion] good; at 3:53 p.m., [R1] complained of left hip pain. Order obtained to get x-ray of left hip; at 7:07 p.m., [R1's] x-ray result positive acute femoral neck fracture...Order to send [R1] to ER [emergency room]; and at 7:34 p.m., Report called to ER, [R1] sent out."

The local hospital document entitled, "Procedure Report," dated 2/19/2016, document, R1's orthopedic surgical intervention included a "closed reduction, percutaneous screw fixation, of the valgus impacted left subcapital fracture."

R1's facility "Progress Notes," dated 2/23/2016, at 11:30 a.m., document R1 returned to the nursing home facility [from the local hospital].

On 3/8/2016, at 1:10 p.m., E5/Licensed Practical Nurse approached R1 to look at R1's left hip. As R1 attempted to stand up, E5 asked R1 to remain seated, in R1's wheel chair, until E5 could put on a pair of gloves and provide R1 with standing assistance. R1 sat back down and as soon as E5 started to put on E5's gloves, R1 stood up

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health

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S9999	Continued From page 3 without assistance. R1 's balance was weak as R1 stood up against E5's recommendation. On 3/8/2016, at 2:20 p.m., E3 stated the following, in regards to the incident on 2-18-16 in R1's room: E3 assisted R1 from the laying position to seated position on the edge of R1's bed; E3 advised R1 to sit still for a while; E3 turned E3's back to R1, in order to grab R1's wheeled walker; R1 then fell to the floor, on R1's left side; E3 stated, "it happened fast" and R1 is "impulsive" and R1 had no complaints of pain when assessed by E4, or during R1's therapy that followed R1's fall. On 3/9/2016, 8:30 a.m., E4 stated, after hearing R1 fall, E4 assessed R1; R1 had no complaints of pain; ROM was completed to R1's lower extremities with no complaints of pain from R1. R1 is "very impulsive" and wants to stand on [R1's] own; and R1 is a fall risk. (A)	S9999		

Attachment A
Statement of Licensure Violations

IMPOSED PLAN OF CORRECTION

Heartland of Moline
Complaint Survey 1621138/IL83753, exit date 3-9-2016

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 shall be followed in operating the facility.

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.

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)

This will be accomplished by:

I. The facility will conduct an investigation of the incident and take appropriate actions to prevent reoccurrence. Policies and Procedures for Falls and Policies and Procedures for Abuse and Neglect will be reviewed and revised as necessary.

II. All nursing staff will be in-serviced on the facility's policy to assess for causative factors contributing to falls and take corrective actions based on said factors for those residents with a history of falls. All staff will be in-serviced on following interventions on care plans to prevent falls. The in-servicing must also include the systemic changes to reasonably assure deficiency does not recur by review of protocol for safety interventions, monitoring, care planning and assessment.

Attachment B
Imposed Plan of Correction

III. The Director of Nursing (DON) and/or Clinical Nurse Leaders, will audit documentation in the medical record for compliance weekly for six (6) weeks and then quarterly in the Quality Assurance meetings. Audits with negative outcomes will result in further education for staff involved and/or possible disciplinary action.

IV. Documentation of in-service training will be maintained by the facility.

V. The Administrator, Director of Nurses, and Quality Assurance Committee will monitor Items I through V to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Ten (10) days from receipt of this Imposed Plan of Correction.

Attachment B
Imposed Plan of Correction