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
	IL6013437	A. BUILDING: ____ B. WING ____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND SENIOR LIVING	101 TROWBRIDGE ROAD NEOGA, IL 62447

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S 000	Initial Comments Annual Licensure and Certification Survey Complaint Investigation 2162444/IL132643	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b) 300.1210d)5) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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

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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:
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

These requirements were not met evidencded by:

Based on observation, interview, and record review the facility failed to implement interventions to prevent the development of an unstageable pressure ulcer for one of three residents (R23) reviewed for pressure ulcers on the sample list of 31. This failure resulted in R23 developing an unstageable pressure ulcer to the left outer ankle.

Findings include:

On 4/21/21 at 2:02 PM, R23's left ankle had a dime size open area to the left outer ankle. The center area of the ulcer had slough (yellow

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material) covering the entire surface of the wound bed.

The facility's incident audit report dated 1/1/21 documents R23 has a unstageable pressure ulcer with eschar due to R23 not keeping feet still while in bed. This incident documents R23 rubs feet while sleeping.

The facilities skin and wound evaluation dated 4/21/21 documents R23 has an in house acquired, "unstageable: Obscured full thickness skin and tissue loss" pressure ulcer.

R23's impairment of skin integrity care plan dated with a 9/16/20 revision date does not include interventions to prevent pressure related to R23 rubbing R23's feet on the bed until 1/4/21 after the pressure ulcer was identified on 1/1/21.

On 4/21/21 at 12:17 PM, V1 Administrator stated R23's pressure ulcer was identified on 1/1/21 and was in house acquired. V1 stated R23 would lay with R23's foot on R23's bed. V1 confirmed R23's intervention of increase monitoring of pillow placement while R23 is in bed was not put into place until 1/4/21 after R23 had already developed the pressure ulcer.

The facility's Prevention of Pressure Wounds policy dated January 2017 documents preventive measures as identifying risk factors for pressure injury development and that, "11. The care process should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions: and to modify the interventions as appropriate."

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" B "

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300.610a)
300.1210b)
300.1210d)6)
300.1220b)2)

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

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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 300.1220 Supervision of Nursing Services

b)The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

These Requirements were not met evidencded by:

Based on observation, interview, and record review, the facility failed to provide supervision and assessed fall interventions to prevent falls for two of three residents R41 and R28 reviewed for falls on the sample list of 31 residents. These failures resulted in R41 suffering a hip fracture

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when staff failed to supervise R41 and remove R41's wheelchair pedals, and R28 suffering fractured vertebrae when staff failed to follow care plan interventions.

Findings include

1.) On 4/22/21 at 10:25 am V41 propelled R41's self out of the dining room and down the hallway.

The Minimum Data Set dated 9/2/20 documents R41 is severely cognitively impaired and requires limited assist of one staff member for transfers.

The Physician Order Sheet dated 9/1/21-10/31/20 documents R41 has diagnoses of Muscle Weakness, Knee Pain, Unsteadiness on feet, History of Falling and Dementia with Behavioral Disturbance.

The Fall Report dated 8/20/20 at 9:16 am documents R41 was found on the floor and that R41 was walking to the bathroom when R41 fell. The Report documents a root cause of the fall as "resident with poor safety awareness attempting to ambulate to the restroom per self. (R41) has shown increased weakness this am." The Report documents a new intervention of "resident placed in wheel chair today and educated on the importance of not ambulating per self. (R41) has the ability to propel self. "

The Fall Report dated 8/20/20 at 10:45 am documents R41 "on the floor again" and that R41 "was sitting on the floor five feet in front of (R41's) wheelchair as (R41) was attempting to ambulate per self." The Report documents the root cause of the fall as "the resident has poor safety awareness and was attempting to ambulate per

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self" and a new intervention of "Resident placed in eye view of the nurse's station to prevent any further falls."

The Fall Report dated 9/30/20 at 4:00 PM documents R41 was found on the floor in front of R41's wheelchair in the lobby. The Report documents the root cause of the fall as "resident is not used to using the wheelchair, usually walks independently. Not able to r/t (related to) strength and knee pain, not used to sitting down for longer periods. The Report documents a new intervention of "If resident is noted to use wheelchair, staff to occasionally ask if resident wants help standing/walking."

The Fall Report dated 10/3/20 documents "This Nurse (V15) was assisting another resident in (resident's) room and was alerted by CNA (unknown Certified Nurses Aide) that resident (R41) was attempting to stand. CNA returned resident to chair and alerted nurse. When CNA and nurse returned to the hallway, resident had fallen in hallway on right side." The Report documents R41 stated "I was trying to stand up and got tangled. I fell on my side." The Report documents R41 complained of extreme right hip pain and R41 was transported to the hospital.

The Radiology Report dated 10/3/20 documents R41 has an intertrochanteric femur fracture.

The Orthopedic Consult Note dated 10/7/20 documents R41 was admitted to the hospital on 10/3/20 after a fall at the facility and that a right hip fracture was confirmed after R41 arrived at the Emergency Department.

The Operative Report dated 10/4/20 documents R41 underwent a right femur nailing on that date

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S9999	Continued From page 7 for a right femur fracture The Fall Follow up note dated 10/4/20 documents "Due to recent illness and weakness noted. Resident is not able to ambulate independently and needs assistance. Resident has dementia and does not recall to wait for help or to use (R41's) call light appropriately. Keep wheelchair pedals off the wheelchair when sitting in it to avoid getting feet tangled up when the resident attempts to get up and walk." On 4/21/21 at 1:40 PM V15 stated R41 had experienced several recent falls and R41 was frequently attempting to self transfer so on 10/3/20 R41 was in the hall in R41's wheelchair so staff could supervise R41. V15 stated a CNA came to the resident room where V15 was working and reported to V15 that R41 was trying to stand and that the CNA returned the resident to the wheelchair. V15 stated when V15 and the CNA returned, R41 was on the floor. V15 stated R41 complained of hip pain and was sent to the hospital and diagnosed with a fractured hip. V15 stated R41 fell when the CNA walked away from R41 to find V15. V15 stated the wheelchair pedals were on the wheelchair and should have been positioned out of the way. On 4/22/21 at 10:15 am V9 Restorative Nurse reviewed R41's Fall Report dated 10/3/20 and stated the fall occurred when the CNA moved away from the resident to get help. V9 stated the 10/3/20 Fall Report documents R41 got tangled in the foot pedals of the wheel chair when R41 stood from the chair and fell. V9 stated the root cause of the fall appears to have been the wheel chair foot pedals. V9 stated R41 can propel R41's self in the wheelchair and wheelchair pedals should only be used when staff are	S9999		

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transporting a resident. V9 also stated the fall might have been prevented if R41 had been supervised.

On 4/22/21 at 1:15 PM V1 Administrator stated "If a resident can propel their wheelchair they should not have pedals on the wheel chair because they might stand up."

The undated Falls and Fall Risk, Managing policy states "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." The policy also states "Staff will identify and implement relevant interventions (e.g. hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling."

2.) On 4/19/21 at 1:30 PM, R28 was standing up walking between the wheelchair and bed. R28's was holding onto the wheelchair using the wheelchair to balance self.

R28's nursing note dated 2/4/2021 at 8:18 AM documents, "(R28) had unwitnessed fall at (5:00 AM) this morning. (R28) reported new onset thoracic discomfort with difficulty in taking a full deep breath." This note documents that R28 was sent to the emergency room for an evaluation.

R28's hospital encounter form dated 2/4/21 documents under history, "fall, back injury, rib pain." This form documents R28 has a compression fracture of the 8th thoracic vertebrae and a displaced fracture of the 1st lumbar vertebrae.

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R28's Fall Risk Assessment documents R28 fell on 2/4/21. This investigation documents the root cause as, "Wheelchair was not at resident's bedside at time of resident's fall." This investigation documents a new intervention to, "Re-educate staff to keep locked wheel chair within (R28's) reach from (R28's) bed as (R28) has impaired safety awareness and will self ambulate."

On 4/21/21 at 12:24 PM, V9 Restorative Nurse stated the staff are trained to ensure all items the residents use are within reach to prevent falls. V9 stated the intervention of ensuring R28's wheelchair was next to the bed was put into place on 11/9/20. V9 stated R28's wheelchair should have been at the bedside. V9 stated the root cause of R28's fall was the wheelchair not being at the bedside.

On 4/22/21 at 1:15 PM, V1 Administrator confirmed that R28's wheelchair was not beside the bed when R28 fell on 2/4/21 and that this was the root cause of the fall. V1 confirmed that R28 did sustain fractures as a result of the fall on 2/4/21.

" A"