STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145031	A. BUILDING _____ B. WING _____	10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF NORMAL	510 BROADWAY NORMAL, IL 61761

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Complaint #1162943 / IL 54614-No Deficiency	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 provide supervision during toileting to one of five sampled residents (R7) at high risk for falls in a total sample of eighteen. This failure resulted in R7 falling and sustaining a pelvic fracture and laceration. This past noncompliance occurred from 6/30/11 to 7/12/11. The findings include: R7's October 2011 Physician's Order Sheet (POS) list diagnoses which includes Syncope and collapse, difficulty walking, muscle weakness, gait abnormality, Hypotension, Osteoporosis and Alzheimer's Disease. R7's Minimum Data Set (MDS) dated 5/02/11 assessed R7 with severe cognitive impairment, requiring extensive assist of one staff for transferring and ambulation, and not steady moving on and off toilet without physical assistance. R7's Care Plan dated	F 323	Past noncompliance: no plan of correction required.	

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

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5/10/11 identified R7 as "Resistive to treatment/care i.e.: showering, bed and chair alarms, medications related to middle stage dementia," and "At risk for falls due to unsteady gait, middle stage dementia, history of falls."

On 10/17/11 at 10:05 am nurse E3 identified R7 as a fall risk. E3 stated that R7 had fallen a few months prior while residing in the nursing home. E3 stated that R7 requires assistance of one staff for transfers and ambulation.

Nurse's Notes dated 6/30/11 at 9:30 am document that E3 was called to R7's room after R7 was found on the floor on her right side. R7 had a laceration and hematoma above the right eye and a deep laceration to the right outer arm. Notes document that R7 complained of pain in the right side and back. R7 was transported to the emergency room for evaluation.

The radiology report dated 6/30/11 identified a fracture of the right pubis and superior ramus on R7.

The facility's Incident Report Summary of Investigation dated 7/03/11 stated "{R7} was toileting, got up and 'blacked out'. {R7}complained of right hip pain and laceration above right eye. Hospital X-ray conclusion was 'fracture of right pubis.'" The report documented the probable cause of fall was due to a syncope episode.

The facility Incident Report Investigation dated 6/30/11 included a Statement of Witness from Certified Nurse Aide (CNA) E5, which documented "{R7} came back from breakfast

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F 323	Continued From page 2	F 323		

and needed to use the restroom (as usual), I put her on the toilet and left the room (not the section though). I was across the hall in another residents room. I kept checking on her , because I could see {R7's} wheelchair from {other resident's} door. I put {other resident}on the toilet with the lift and told her I would be back. I walked out of the room and went straight to {R7's} room across the hall to find {R7} lying on the floor...face down, and wasn't moving. I put my arm under her neck and there was blood.. She asked to get up ; I told her I couldn't until a nurse came. I asked her what happened - She said 'I think I blacked out'." The report documented that R7 was lying between the two beds in the room and her wheelchair was parked between the bathroom door and the bedroom door. The Witness Statement by E5 also included the question by E2, Director of Nursing and E9, Human Resources who conducted the interview, "What is the facility policy regarding fall risk and restrooms:" E5 responded, "Stay with resident at all times."

Nurse E3's witness statement dated 6/30/11 documented that E3 was called to the room by E5. E3 documented that no alarm was sounding when she entered the room and E5 had stated that she put R7 on the toilet and went into the hallway. Then when E3 went back into R7's room, she found R7 on the floor.

E3 confirmed on 10/19/11 at 1:45 pm that R7 had been left unattended on the toilet and had fallen. R7 had gotten off the toilet and was on the floor between the beds. R7 had not used the emergency nurse call light and no fall alarms were sounding. E3 confirmed that R7 was a high fall risk, with a history of syncope and vagal

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F 323	Continued From page 3	F 323		

events when toileting. E3 stated the facility policy is that staff should stay with residents who are high fall risk during toileting.

Nurse/MDS Coordinator E5 stated during interview on 10/19/11 at 12:25 pm, "If a resident is a fall risk, requires alarms or needs assistance to get to the toilet, someone needs to stay with them at all times to prevent falls".

R7's Nurse's Notes document incidents of unresponsiveness while on the toilet on 4/22/11 and 5/07/11, and one fall in the bedroom on 5/16/11.

Prior to the survey date of 10/20/11, the facility had taken the following actions to correct the non-compliance:

On 6/30/11, E5 was suspended, R7's doctor and family were notified, and R7 was sent to the emergency room. The fall investigation was initiated. The Quality Assessment and Assurance Committee (QAA) met and established an audit tool.

On 6/30/11 and 7/01/11, the facility inserviced 79 nursing employees on the topic "Toileting Residents with Alarms." The inservice content; "Do Not leave an alarmed resident on the toilet by themselves!, If you need additional assistance, please yell for assistance. You can only take care of one person at a time!"

On 7/05/11 the final investigation report stated that E5 was terminated, and that the facility continued to conduct audits from 7/01-7/05/11 to ensure resident alarms were in place and

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F 323	Continued From page 4 functioning and that staff stay at the bathroom door for residents with alarms. The facility met daily or every other day through 7/12/11 to evaluate any subsequent falls, and continue to monitor falls and do random audits, according to E2 on 10/19/11 at 12:00pm.	F 323		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	F9999		

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F9999	Continued From page 5	F9999		

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 procedures:

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

There Regulations were not met as evidenced by:

Based on record review and interview the facility failed to provide supervision during toileting to one of five sampled residents (R7) at high risk for falls in a total sample of eighteen. This failure resulted in R7 falling and sustaining a pelvic fracture and laceration. This past noncompliance occurred from 6/30/11 to 7/12/11.

The findings include:

R7's October 2011 Physician's Order Sheet (POS) list diagnoses which includes Syncope and collapse, difficulty walking, muscle weakness, gait abnormality, Hypotension, Osteoporosis and Alzheimer's Disease. R7's Minimum Data Set (MDS) dated 5/02/11 assessed R7 with severe cognitive impairment, requiring extensive assist of one staff for transferring and ambulation, and not steady moving on and off toilet without physical assistance. R7's Care Plan dated 5/10/11 identified R7 as "Resistive to

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F9999	Continued From page 6	F9999		

treatment/care i.e.: showering, bed and chair alarms, medications related to middle stage dementia," and "At risk for falls due to unsteady gait, middle stage dementia, history of falls."

On 10/17/11 at 10:05 am nurse E3 identified R7 as a fall risk. E3 stated that R7 had fallen a few months prior while residing in the nursing home. E3 stated that R7 requires assistance of one staff for transfers and ambulation.

Nurse's Notes dated 6/30/11 at 9:30 am document that E3 was called to R7's room after R7 was found on the floor on her right side. R7 had a laceration and hematoma above the right eye and a deep laceration to the right outer arm. Notes document that R7 complained of pain in the right side and back. R7 was transported to the emergency room for evaluation.

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The facility Incident Report Investigation dated 6/30/11 included a Statement of Witness from Certified Nurse Aide (CNA) E5, which documented "{R7} came back from breakfast and needed to use the restroom (as usual), I put

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F9999	Continued From page 7	F9999		

her on the toilet and left the room (not the section though). I was across the hall in another residents room. I kept checking on her , because I could see {R7's} wheelchair from {other resident's} door. I put {other resident}on the toilet with the lift and told her I would be back. I walked out of the room and went straight to {R7's} room across the hall to find {R7} lying on the floor...face down, and wasn't moving. I put my arm under her neck and there was blood.. She asked to get up ; I told her I couldn't until a nurse came. I asked her what happened - She said 'I think I blacked out'." The report documented that R7 was lying between the two beds in the room and her wheelchair was parked between the bathroom door and the bedroom door. The Witness Statement by E5 also included the question by E2, Director of Nursing and E9, Human Resources who conducted the interview, "What is the facility policy regarding fall risk and restrooms:" E5 responded, "Stay with resident at all times."

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E3 confirmed on 10/19/11 at 1:45 pm that R7 had been left unattended on the toilet and had fallen. R7 had gotten off the toilet and was on the floor between the beds. R7 had not used the emergency nurse call light and no fall alarms were sounding. E3 confirmed that R7 was a high fall risk, with a history of syncope and vagal events when toileting. E3 stated the facility policy

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F9999	Continued From page 8 is that staff should stay with residents who are high fall risk during toileting. Nurse/MDS Coordinator E5 stated during interview on 10/19/11 at 12:25 pm, "If a resident is a fall risk, requires alarms or needs assistance to get to the toilet, someone needs to stay with them at all times to prevent falls". R7's Nurse's Notes document incidents of unresponsiveness while on the toilet on 4/22/11 and 5/07/11, and one fall in the bedroom on 5/16/11. (B)	F9999		