STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145012	A. BUILDING _____ B. WING _____	01/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF GALESBURG	280 EAST LOSEY STREET GALESBURG, IL 61401

(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 323	Continued From page 3 report due to increased pain. The physician was contacted on three or more different occasions requesting x-rays and scheduled pain medication. Resident was admitted to hospital for a fractured left neck femur and repair. This was five days after 2 falls (9/29 at 9:15 PM and 9/27/12 at 11:00 AM.) had occurred. Hipsters were never attempted or assessed by therapy as stated for intervention. This intervention was deemed not appropriate due to increased pain issues resulting in a fracture after two x-rays completed."	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210a) 300.1210b)4) 300.1210b)5) 300.1210c) 300.1210d)6) 300.3240a) 300.3240b) 300.3240c) 300.3240d) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which	F9999		

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F9999	Continued From page 4 allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents'	F9999		

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F9999	Continued From page 5 respective resident care plan. 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) Based on record review and interview, the facility failed to analyze fall history, determine root cause for falls, and develop and implement individualized care plan interventions for fall prevention for two residents (R5 and R6) of 13 evaluated for fall histories in a total sample of 15. R5 and R6 sustained hip fractures. Findings include:	F9999		

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F9999	Continued From page 6	F9999		

1. The facility's Monthly Safety Tracking Logs for January through December 2011 indicated that R6 had experienced falls on 1/1, 1/6, 3/20, 6/2, and 10/8/11. The logs indicated that R6 sustained a laceration during the fall on 3/20/11 and a fracture on 10/8/11.

R6's care plan dated 12/28/11 instructed staff in the Intervention section for R6's fall risk problem,"Do not leave unattended in room when in wheelchair." This intervention was noted as having been added to the care plan on 3/20/11.

An incident report dated 10/8/11 indicated that R6 was found lying on her left side on the floor of her room in front of the sink at 10 AM on that date. The facility's investigation report dated 10/8/11 for this incident indicated that after complaints of pain in the left hip, an x-ray of R6's left hip showed a left femoral neck fracture. The report also stated that R6 was then transferred to the hospital for fracture treatment.

A written account of an interview done with E4 (Licensed Practical Nurse) on 10/8/11, as part of the facility's investigation, indicated that E4 found R6 earlier that morning lying on her left side on the floor of her room next to R6's wheelchair.

E4 stated on 1/9/12 at 2:45 PM that R6's incident of 10/8/11 occurred during a period when R6 was alone in her room, so the fall was not witnessed. E4 said that R6 was found in front of the room sink, and R6 frequently used the sink for brushing her teeth.

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F9999	Continued From page 7	F9999		

2. R5 has had three admissions and discharges to the hospital from 1/7/1 1 through 11/1/11 with at least 18 documented falls since his initial admission of 1/7/11 at the facility. R5's Minimum Data Set of 10/17/11 for a significant change noted R5 is "total dependence- requiring full staff performance every time during the entire 7-day period" with "one person physical assist." Section J1800 is not addressed for a fall history on admission.

Fall investigation-incident report for 1/28/11 fall for R5 states under #12: "Results of investigation: resident has cognitive impairment-dementia. Resident stood up and missed the chair when trying to sit back down. No injuries noted. Will continue with current plan of care. Care plan was in place at time of the incident." No new approach was evidenced.

Interview with the Director of Nurses, E2, on 1/10/12 at 10:00 am verified that the falls of 1/28, 4/11 and 8/11 were not addressed with new careplan interventions. The three falls were not specifically identified with careplan up-dates for each of the individual falls, rather summarized together without dates to identify the related fall to the new intervention. On 1/11/12 at 9:20 am the Director of Nurse, E2, verified that the care plan staff were not aware that the care plans did not include all the interventions for falls individually addressed.

The facility's documentation on the Comprehensive Assessment does not show any entries under the "history of falling" to analyze the findings. Past history of falls at the facility with

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F9999	Continued From page 8 conclusions about the root causes with contributing factors related to previous falls were not identified and summarized to prevent further incidents. The hospital physical and history of admission of 10/5/11 states " Fell about a week ago. Apparently an xray was negative or not done. Had an xray done at nursing home and showed a femoral neck fracture. (R5) is bedridden with assistance so the pain in the hip wasn't identified by weight bearing." Incident report of 10/3/11 entry entered by E5, Registered Nurse, Director of Care Delivery, "The hipster's were not applied after incident report due to increased pain. The physician was contacted on three or more different occasions requesting x-rays and scheduled pain medication. Resident was admitted to hospital for a fractured left neck femur and repair. This was five days after 2 falls (9/29 at 9:15 PM and 9/27/12 at 11:00 AM.) had occurred. Hipsters were never attempted or assessed by therapy as stated for intervention. This intervention was deemed not appropriate due to increased pain issues resulting in a fracture after two x-rays completed." (B)	F9999		