

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER HEARTLAND CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 101 TROWBRIDGE ROAD NEOGA, IL 62447		
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F 323	Continued From page 10	F 323			
F9999	<p>FINAL OBSERVATIONS</p> <p>LICENSURE VIOLATIONS</p> <p>300.1210b) 300.1210d)6 300.1220b)2)3 300.3240a)b)</p> <p>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 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.</p>	F9999			

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F9999	Continued From page 11 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. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. 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. These Regulations were not met as evidenced by:	F9999			

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F9999	Continued From page 12 A. Based on interview and record review the facility failed to assess and develop targeted interventions related to fall potential and medication side effects for R11. R11 sustained a Subdural Hematoma related to a fall which required hospitalization. R11 is one of seven residents reviewed for falls in a sample of 15. Findings include: The Physician's Order Sheet (POS) dated February to May 2012 for R11 lists the following diagnoses: Aftercare for Healing Traumatic Fracture of Right Hip, Above Knee Right Leg Amputation and Intracranial Hemorrhage. The facility's form titled Fall Risk Assessment dated 1/27/12 lists R11 as High Risk for Falls and has a history of falls. The MDS (Minimum Data Set) dated 2/16/12 states R11 is an extensive assist with two plus staff for bed mobility, totally dependent on staff for all transfers and toileting. The Medication Administration Record (MAR) and Nurses Notes dated February 5, 2012 for R11 documents that R11 received the following medications: Trazodone 50 mg (milligrams) at 8:00 PM , Hydrocodone-Acetaminophen 5-325 mg two tablets at 8:10 PM and Valium 5 mg at 8:17 PM. All three of these medications have an adverse reaction/side effect of sedation according to the reference Lexi-comp Geriatric Dosage Handbook 13th Edition. The facility's form titled Incident Log dated February 2012 states R11 had a fall on 2/5/12 in her room that required hospitalization. R11's Nurses Notes dated 2/5/12 at 10:31 PM reads	F9999			

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F9999	<p>Continued From page 13</p> <p>"(R11) found on floor of her room at 9:40 PM next to her bed. She was lying on her left shoulder with her left buttock lodged on foot of IV (Intravenous) pole . (R11) screamed out in severe pain when repositioned to supine position. Unable to move extremities without complaints of severe pain." Nurses Notes dated 2/5/12 at 9:25 PM states R11 was transferred to the hospital per ambulance.</p> <p>The Facility's incident report dated 2/5/12 states "(R11) heard yelling and crying out. Upon entering residents room found (R11) lying on the floor next to her bed, face down with weight on left shoulder and right arm lodged behind her. (R11)left buttock was lying on the foot of IV pole. (R11) stated that her back and hips hurt badly. Incident report also reads R11 stated "I went to turn over and just kept on rolling off the bed." The same report continues to state under the section titled "Other" reads "(R11) has been crying with increased anxiety caused by severe pain this shift. Pain meds given at 8 PM."</p> <p>The Hospital X-Ray Report dated 2/5/12 titled "CT (computed tomography) HEAD WITHOUT CONTRAST" reads under "Impression" "Hyperdensities suggesting parenchymal hemorrhage in right parietal lobe adjacent to the tentorium medially and peripherally as well as in the high right parietal lobe in the parafalcine region. Thickened hyperdensity along falx compared to prior study represent small subdural hemorrhage..."</p> <p>R11's Nurses Notes dated 2/6/12 at 3:12 AM states the facility called the hospital emergency room for an update and was informed that R11</p>	F9999			

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F9999	<p>Continued From page 14 was admitted to ICU (Intensive Care Unit).</p> <p>On 8/24/12 at 10:10 AM E7, LPN (Licensed Practical Nurse) stated ".....Other than the initial protocol for high fall risk residents" E7 did not believe the nurse put anything into place for the fall (R11) had. E7 stated "there is a list of interventions that is available to the nurses to use for residents identified as high fall risk. I would of put (R11) into a low bed and floor mat....."</p> <p>E2, Director of Nurses stated on 8/24/12 at 11:10 AM " I would have expected the nurse to put on the communication sheet that (R11) was a fall risk and the medication (R11) received prior to her fall. I would of expected that (R11) to be given a low bed and /or a mat beside the bed. There should of been interventions in place for (R11) due to her high fall risk status."</p> <p>E8, LPN Restorative Nurse stated on 8/24/12 at 9:30 AM that she was not aware of any fall intervention R11 had in place for falls.</p> <p>R11's Initial Plan of Care dated 1/27/12 under the section titled "Falls" lists the following interventions, fall protocol, complete fall risk assessment, provide assistive devices as need and therapies to screen, evaluate and treat per physician's orders. The care plan dated 1/30/12 does not address R11's fall interventions.</p> <p>B. Based on interview and record review the facility failed to comprehensively assess for the root cause of resident to resident physical aggression involving R8 and R10. The facility</p>	F9999			

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F9999	<p>Continued From page 15</p> <p>failed to document behavioral tracking for the aggressor, R10, failed to develop and implement targeted interventions for R10, and failed to document this problem or interventions in the plans of care for R8 and R10. R8 and R10 are two of six residents reviewed for behaviors on the sample of 15.</p> <p>Findings include the following:</p> <p>R10's Behavioral Progress notes dated 5-14-12 7:35 p.m. states R10 "...ran (wheelchair) into another resident and when other resident told him to move and stop running over her, he grabbed (her wheelchair) arm and began shaking it. When she told him to let go and stop he began hitting her on the right arm with closed fist." The intervention listed states "separated by this nurse". The resident response states "continued to yell at the nurse saying that the other resident needed to leave because she didn't belong here..." The note continues that the victim sustained no injuries.</p> <p>On 8-23-12 at 10 a.m. E8 Licensed Practical Nurse identified the victim to be R8.</p> <p>R10's Behavioral Progress Notes dated 6-27-12 at 9:02 p.m. states "...resident slapped another resident in the sun room...hit other resident's wheelchair and when other resident asked him to move he slapped her in the shoulder..." The intervention listed states "removed resident from sun room and instructed not to hit other residents". The resident response states "well she made me mad, and if she makes me mad I will hit her again..." The note states that the victim sustained no injuries.</p>	F9999			

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F9999	Continued From page 16 On 8-23-12 at 10 a.m. E8 Licensed Practical Nurse identified the victim to be R8. E8 indicated that both of these incidents occurred in the sun room. R10's August 2012 Physician Order Sheet includes diagnoses including Unspecified Intracranial Hemorrhage, Encephalopathy Unspecified, Dementia with Behavioral Disturbances, and Anxiety State. R8's August 2012 Physician Order Sheet includes diagnoses including Alzheimer's and Other Persistent Mental Disorder. R10's Behavior Tracking documentation from March to August 2012 reflects no behavior monitoring, tracking, or documentation related to resident to resident aggression. Behavioral Tracking documentation is only specific to Verbal/cursing at staff, Physical to staff during ADL's (activities of daily living) care, Restlessness, fidgeting, repetitive movements, disrobing, tearfulness/due to loss of his wife, elopement attempts. R10's Care Plan dated 6-28-12 includes a problem which states "...has been verbal/cursing at staff when he is agitated, tearful, physically aggressive, restless, and attempts elopement..." Goals include "...will have no episodes of being physically aggressive through next review..." Interventions include "...Record behaviors on tracking forms..." The Care Plan fails to include a problem statement of aggression to other residents (R8) and fails to include planned interventions to address two previous assaults on	F9999			

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F9999	<p>Continued From page 17</p> <p>the same resident, occurring in the same location, at the same relative time of day, over the course of the previous 45 days.</p> <p>E6, Social Service Director stated on 8-23-12 at 2 p.m. that she is responsible for behavioral management in the facility. E6 stated that while not documented, she had knowledge that R8 and R10 knew each other in the community prior to admission and had open conflict with one another. E6 stated familiarity with R10 and his long standing history of head injuries due to a motor vehicle accident, the death of his spouse, his frequent delusional tendencies, and his progressing dementia. E6 stated that R8 and R10 both often spent time in the sun room watching television at the same time.</p> <p>E6 stated that while not documented, the planned intervention following the 5-14-12 incident was to keep R8 and R10 separated. E6 stated that the expectation was for staff to continue keeping R8 and R10 separated. E6 stated that this plan or other specific, targeted interventions addressing R10's aggression toward R8 was never formalized and Care Planned. E6 stated that she had not been involved with an assessment of root causes leading to R10's aggression. E6 stated that E1, Administrator was mainly in charge of completing this.</p> <p>E1 stated on 8-23-12 at 4 p.m. that documentation related to R10's behaviors was incomplete and that a comprehensive root cause analysis was not completed.</p> <p>Facility policy titled Resident Allegation of Resident Abuse dated 11-11-12 states "...Any</p>	F9999			

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F9999	Continued From page 18 resident suspected of abuse to another resident, based on credible evidence, will be immediately evaluated to determine the most suitable intervention and resident placement...the Abuse Prevention Coordinator or his/her designee will arrange for the Director of Nursing/Administrator of Clinical Services to immediately contact the attending physician to request an evaluation to determine a suitable course of therapy or intervention...This intervention will be documented in the clinical record... <p style="text-align: center;">B</p>	F9999			