

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/10/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND OF PEORIA			STREET ADDRESS, CITY, STATE, ZIP CODE 5600 GLEN ELM DRIVE PEORIA, IL 61614		
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F 328	Continued From page 16 The surveyor confirmed through interview and record review the facility took the following actions to remove the Immediate Jeopardy: 1. 10/2/13 licensed staff have received education regarding the (Corporate) policy on tracheostomy tubes. This education was conducted by the Administrative Director of Nursing and Assistant Director of Nursing. Information covered include: *Tracheostomy tube insertion/reinsertion *Tracheostomy maintenance *Tracheostomy emergencies *Tracheostomy management Those employees not able to attend the education will be educated before their next scheduled shift. If not scheduled to work, education will be completed by 10/5/13. 2. 10/2/13 all residents with tracheotomies have been assessed by a Registered Nurse. Documentation of assessment was completed on 10/2/13. 3. Initiated 10/2/13 the Administrative Director of Nursing or designee will review nursing Progress Notes five times per week for 4 weeks, to ensure facility protocols are followed for patients with tracheotomies following a change in condition. Report of findings will be given to Administrator weekly and reviewed by the QAA committee monthly for further recommendations as needed. The Administrator will be responsible for assuring that compliance is attained and maintained.	F 328			
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS	F9999			

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F9999	Continued From page 17 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)6) 300.1220b)2) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.	F9999			

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F9999	Continued From page 18 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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and	F9999			

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F9999	<p>Continued From page 19</p> <p>determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.</p> <p>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> <p>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.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements were not met as evidence by:</p> <p>Based on record review and interview the facility failed to immediately consult with R4's Physician regarding an incident involving tracheostomy decannulation. The facility also failed to follow</p>	F9999			

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F9999	<p>Continued From page 20</p> <p>established policy and procedure in order to adequately monitor and intervene to prevent a reoccurrence of a life threatening situation. The facility also failed to put interventions in place to prevent potentially fatal air hunger for R4. These failures resulted in a second incident of tracheostomy decannulation. Which resulted with R4 being found without respirations at the facility after experiencing a second tracheostomy decannulation two days after an initial decannulation. R4 is one of four residents reviewed for tracheostomy care in a sample of sixteen.</p> <p>Findings include:</p> <p>R4's September 2013 Physician's Order Sheet (POS) list the following diagnoses: Brain Injury with Open Wound, Dysphasia, Chronic Respiratory Failure, Cognitive Communication Deficit, Tracheostomy and Gastrostomy.</p> <p>R4's admission Nurses Notes dated 9/13/2013 document that R4 "...has a portex trach... (R4) is on continuous oxygen...(R4) is resting in bed".</p> <p>R4's September 2013 POS includes the following Physician's orders: Oxygen at 6 to 10 liters/ minute to keep oxygen saturations greater than 90 percent. Duo nebs every four hours per nebulizer. Tracheostomy care every shift. Tracheostomy: Portex 8 millimeter cuff. Change trachea inner cannula daily. Suction as needed for excessive secretions. Change trachea ties weekly. Pulse Oximetry every shift. Right side hand mitt, remove every two hours and clean hand. Change oxygen tubing and mask weekly.</p>	F9999			

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F9999	<p>Continued From page 21 And oxygen at ten liters with 28% humidity.</p> <p>R4's Care Plan, dated 9/13/13, instructs staff to..." evaluate lung sounds and vital signs as needed, obtain pulse oximetry and report abnormal findings, administer oxygen as per physician order, trachea care per protocol, wear right arm mitten to prevent pulling trachea out and report abnormalities to physician..."</p> <p>R4's Nurses Notes dated 9/14/13 at 06:10 A.M. state"... restlessness noted thru the night, noted resident pulling off trach mask several times thru the night..."</p> <p>R4's Nurses Notes dated 9/16/13 at 06:53 A.M. state"...moving arms trying to pull at pillow and tubes...needs repositioned several times has been scooting down in bed with feet hanging off of bed..."</p> <p>R4's Nurses Notes dated 9/17/13 at 00:03 A.M. state "... patient (R4) is restless and feet are off bed. When nurse entered the room it was noted (R4) had pulled trach out. (R4) was looking around with very wide eyes. Trachea Kit removed from bedside drawer and reinserted into Tracheostomy hole in neck... (R4) had removed mitt and had took apart the O2 tubings and pulled out trach..".</p> <p>R4's Nurses Notes dated 9/17/13 at 02:07 A.M. state"... (R4) continues to be restless, squirming about the bed..."</p> <p>R4's Nurses Notes dated 9/17/17 at 10:42 A.M. state"...resident frequently pulling at trach mask and pulling off. (R4) also moving around in bed, kicking feet off side of bed..."</p>	F9999			

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F9999	Continued From page 22 R4's Nurses Notes dated 9/18/13 at 03:15 A.M. state "...had been moving arms and pulling on tubes...repositioned several times d/t (due to) (R4) moving about in bed and scooting down in bed..." R4's Nurses Notes dated 9/19/13 at 02:10 A.M. state"(R4) restless at this time, (R4) has removed his mit...(R4) is moving left arm and hand more tonoc..during trache care (R4) put arms above head..." R4's Nurses Notes dated 9/19/13 at 02:45 A.M. state"(R4) had removed the trache mask with (R4)'s left hand and had mit almost off right hand..." R4's Nurses Notes dated 9/19/13 at 03:05 A.M. state..." was call (ed) to (R4) room stat. (R4) was laying with (R4)'s trache pulled out, it was laying on (R4)'s chest. (R4) had no respirations...Staff continued CPR (Cardiopulmonary Resuscitation) and 911 was called..." On 9/25/13 at 08:30 A.M. E8 (Licensed Practical Nurse) stated " ...On the night of september seventeenth I was making my rounds at midnight and noticed (R4)'s feet were off of the bed. I could hear (R4) thrashing around in bed. When I went into the room (R4)'s eye was wide open. (R4) looked frantic. I noticed (R4) 's trach mask was laying on (R4)'s shoulder and (R4)'s trach had come all the way out. It was lying on (R4)'s neck next to the opening. I reached into (R4)'s drawer right next to the the bed and got the new one and immediately put it into the hole. I put new trach ties on and then reapplied the trach mask. I	F9999			

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F9999	<p>Continued From page 23</p> <p>did not check (R4)'s oxygen level. After awhile, I guess three to four minutes, (R4) calmed down was breathing normal. I did not notify the Physician or the Respiratory Therapist when (R4) pulled (R4)'s trach out on September seventeenth. I didn't know I was supposed to..."</p> <p>On 9/24/13 at 2:35 P.M. via telephone, Z1 (Respiratory Therapist) stated"...I had worked with (R4) since (R4) was admitted to the facility. (R4) was able to maintain his oxygen levels without oxygen for fifteen, maybe twenty minutes...(R4) could not tolerate being without (R4)'s trach at all. I would have never attempted to try (R4) without (R4)'s trach at this time. (R4) could not tolerate being without it...No staff ever told me that (R4) had pulled (R4)'s trach out. If I had know that I would have immediately spoken with the staff to help them understand the importance of preventing that from happening. I would have instructed the staff to make sure (R4)'s trach ties were tight. And I would have told them the importance of putting mitts on both hands. Most our facilities do that anyway as standard precautions".</p> <p>On 10/1/13 at 02:30 P.M. Z2 (Physician) stated " the facility did not notify me that (R4) had pulled his trachea out on 9/17/13... If I had known this information, I would have recommended that the facility watch (R4) more closely, immediately replace (R4)'s trachea if it came out, monitor (R4)'s oxygen levels and notify me."</p> <p>Facility policy titled " Respiratory: Tracheostomy Tube Insertion/ Reinsertion," dated 01/2011, states" ... a licensed nurse may reinsert the tube to restore the airway. If this occurs,... the tube is reinserted using the quickest means possible.</p>	F9999			

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F9999	<p>Continued From page 24 Physician is then notified..."</p> <p style="text-align: center;">(A)</p> <p>300.610a) 300.1210a) 300.1210b)4)5) 300.1210c) 300.1210d)6) 300.3240a)</p> <p>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.</p> <p>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</p>	F9999		

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F9999	Continued From page 25 and psychosocial needs that are identified in the resident's comprehensive assessment, which 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	F9999			

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F9999	<p>Continued From page 26</p> <p>effort to help them retain or maintain their highest practicable level of functioning.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements were not met as evidence by:</p> <p>Based on interview and record review, the facility failed to provide supervision to prevent a fall for one of three residents (R6) reviewed for falls in the sample of sixteen. The failure to provide supervision resulted in R6 sustaining a right femur fracture. An x-ray report dated 9/19/13, documents R6 sustained a right femur fracture.</p> <p>Findings include:</p> <p>Current Physician Orders, documents R6 is an 82 year old female with diagnoses which include Osteoarthritis, Weakness, and Lack of</p>	F9999			

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F9999	<p>Continued From page 27 Coordination.</p> <p>A Minimum Data Set dated 8/11/13, documents R6 is independent with decision making skills with no short or long term memory problems, and requires extensive assistance with transfers and toileting needs.</p> <p>An Activities of Daily Living (ADL) Task List dated 9/18/13, documents R6 requires extensive assist of two and is a fall risk.</p> <p>Nurses Notes, dated 9/8/13 at 1:45 p.m. and 9/14/13 at 1:06 p.m., document R6 requires extensive assistance of one for most ADL's.</p> <p>A Plan of Care dated 8/1/13, documents R6 is at risk for falls due to unsteady gait and history of falls.</p> <p>A Therapy progress note dated 9/19/13, documents R6 requires moderate assistance with transfers and maximum assistance with toileting.</p> <p>An Incident Report dated 9/18/13 at 7:30 p.m., states (R6) transferred self from commode to bed and fell; (R6) complained of right leg pain; Investigation started and continues."</p> <p>An x-ray report dated 9/19/13 at 12:18 a.m., documents R6 had a fractured right femur.</p> <p>An Investigation Summary titled "(E7)" (date unknown), documents E7 (Certified Nurse Aide) was suspended "due to the fact that (E7) was not with (R6) that needed assist while (R6) was on the commode."</p> <p>On 9/24/13 at 12:45 p.m., R6 stated R6 was in</p>	F9999			

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F9999	<p>Continued From page 28</p> <p>bed and turned on the call light for assistance with toileting. R6 stated E7 (Certified Nurse Aide) came in and told R6 to be more independent since R6 was going home in a few days. R6 stated E7 stood by her while R6 transferred to a commode directly next to R6's bed. R6 stated E7 was standing at the foot of R6's bed looking at the television. R6 stated R6 attempted to "clean myself" and started to stand up when R6's right knee gave out and R6 fell down on right knee. R6 stated "the pain was terrible and E7 had a hard time getting R6 off the floor and into the bed. E7 stated R6 did not use a gaitbelt at any time. R6 stated "I hate to say anything to get (E7) in trouble. I was hesitant to tell on (E7) that night for the same reason."</p> <p>On 9/24/13 at 11:10 a.m., E7 stated on 9/18/13 at approximately 7:30 p.m., R6 was on the commode and E7 had turned away from R6. E7 stated when E7 turned around R6 was down on R6's right knee on the floor. E7 stated R6 complained of right knee pain. E7 stated R6 was transferred to bed per R6's request. E7 stated there were no other witnesses to R6's fall. E7 stated R6 had attempted to transfer independently in the past. E7 stated a few weeks prior to R6's fall on 9/18/13, R6 had transferred to bed independently. E7 stated "I told (R6) it wasn't safe and to ask for assistance." E7 stated E7 was suspended on 9/19/13 for R6 falling and an investigation was being conducted. E7 stated E7 reviewed R6's most recent "kardex" after R6 had fallen and the kardex documented R6 required two assist with transfers.</p> <p>On 9/24/13 at 10:40 a.m., E3 (Assistant Director of Nursing) stated any time a resident requires assistance with transfers a gait belt should be</p>	F9999			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/10/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND OF PEORIA			STREET ADDRESS, CITY, STATE, ZIP CODE 5600 GLEN ELM DRIVE PEORIA, IL 61614		
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F9999	<p>Continued From page 29 used.</p> <p>On 9/24/13 at 2:15 p.m., E8 (Physical Therapist) stated R6 required extensive assistance with transfers. E8 stated not only did R6 have a right knee deformity due to previous surgeries but R6 had poor upper body strength and struggled to push up to stand. E8 stated no recommendations had been made to the Nursing Department for R6 to be more independent with transfers. E8 stated R6 was at risk for falls and not safe to transfer independently.</p> <p>On 9/24/13 at 11:45 a.m., E1 (Administrator) stated E7 (Certified Nurse Aide) was suspended for discrepancies in the story of R6's fall on 9/18/13. E1 stated an investigation was conducted and E7 is being terminated for not providing assistance for R6 that resulted in a fall with injury.</p> <p style="text-align: center;">(B)</p>	F9999			