

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/25/2013
NAME OF PROVIDER OR SUPPLIER HEARTLAND OF DECATUR			STREET ADDRESS, CITY, STATE, ZIP CODE 444 WEST HARRISON STREET DECATUR, IL 62526		
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F 371	Continued From page 39 and Medicaid Services (CMS-672) "Resident Census and Conditions of Residents" form completed on 9-23-13, 104 resident resides at the facility.	F 371			
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.1210d)6) 300.3240a) 300.3240b) 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	F9999			

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F9999	<p>Continued From page 40</p> <p>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.</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. (Section 2-107 of the Act)</p> <p>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)</p> <p>THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY:</p> <p>Based on interview and record review the facility failed to follow a Care Plan to use a mechanical lift while performing a resident transfer for R1 which resulted in R1 sustaining a fractured femur and a subsequent delay in treatment for ten days. R1 is one of nine residents (R1) reviewed for</p>	F9999			

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F9999	<p>Continued From page 41 accidents/incidents in a sample of 24.</p> <p>Findings include:</p> <p>A Physician's Order Sheet (POS) dated 9/2013 documents that R1 has diagnoses which include: Osteoporosis, Dysphagia, Dementia, Lack of Coordination.</p> <p>A Minimum Data Set dated 5-03-13 documents that R1 requires extensive assistance of two people for transfers, and has impairment to both upper and lower extremities which interferes with daily functions or place R1 at risk of injury.</p> <p>A task Kardex dated 4-12-12 and used by Certified Nurse Aides for R1's care instructions, documents that R1 requires two people using a mechanical lift for transfers. A Care Plan dated 9-27-09 also documents that R1 requires two people using a mechanical lift for transfers.</p> <p>A facility policy on abuse titled Patient Protection Practice Guide dated 2011 documents that neglect is a "key component" in the facility's abuse prevention program." The guide documents that, "'Neglect' means failure to provide goods and services necessary to avoid physical harm..." The policy also documents that, "An injury should be classified as an 'injury of unknown source' when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and, the injury is suspicious because of the extent of the injury or the location of the injury..." The policy goes on to explain that an example of a suspicious injury might include, "... the injury is located in an area not generally vulnerable to</p>	F9999			

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F9999	<p>Continued From page 42</p> <p>trauma or the incidence of injuries over time." The policy also indicates that, "the facility must have evidence that all alleged violations are thoroughly investigated." and that the facility must, "ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source...are reported immediately to the administrator of the facility."</p> <p>A facility Incident Report dated 7-08-13 documents that R1, "was found to have bruising to (R1's) right inner thigh and right groin/pelvic area. Shortening of the right leg and outward rotation was also noted." The incident report also documents that an Xray was performed and indicated R1 had a fracture to the right upper leg. The incident report documents that R1, "has not had a recent fall in the facility...(R1) has been dependent on staff for transfers and unable to ambulate for several years." The facility incident investigation documented that on 6-28-13 E8 and E9 (Certified Nurse Aides) were transferring R1 to bed. E8 verified in a written statement dated 7-12-13 that R1 was transferred to bed by E8 and E9 on 6-28-13. E8 stated that, "...we went under (R1's) arms and with (R1's) (incontinence brief)." E8 confirmed that a mechanical lift was not used to transfer R1 as instructed in R1's care plan. In E8's statement, E8 stated that R1 complained of pain after the transfer. In another statement dated 7-26-13, E8 stated that E9 had actually transferred R1 without E8's assistance. E8 stated that on 6-28-13 E9 called E8 into R1's room because, "(R1) was hollering...(R1's) leg looked sloppy...I did tell (E9) to report what (E9) saw to the nurse."</p> <p>Nurse's notes dated 6-28-13 to 7-07-13 contain no documentation that E8 or E9 reported R1 had</p>	F9999			

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F9999	<p>Continued From page 43</p> <p>been transferred to bed without using a mechanical lift or that R1's leg had "looked sloppy" after the transfer, or that R1 experienced pain during the transfer.</p> <p>On 9-24-13 at 9:20a.m. E17 (Certified Nurse Aide/CNA) stated that E17 was scheduled as R1's CNA on a regular basis. E17 stated that R1 had no visible bruising 6-28-13 to 7-01-13 but on Tuesday 7-02-13 E17 noted bruising to R1's groin. E17 stated that R1 had bruising to the groin which was "purplish blue." E17 stated that R1's bruising "looked new" and that E17 told E18 (Licensed Practical Nurse) who was R1's nurse that day. E17 stated that E18 looked at the bruise. E17 also stated that R1's bruising was "passed on" in report to the oncoming CNA. E17 (Certified Nurse Aide) stated that on Thursday 7-04-13, E17 noted that R1's bruise was worse. E17 stated that E17 told E13 (Licensed Practical Nurse), who was R1's nurse at that time.</p> <p>On 9-24-13 at 9:25a.m. E18 (Licensed Practical Nurse) stated that on 7-02-13 E17 (Certified Nurse Aide), "...came and told me that (R1) had a bruise in the groin area. It was all yellow. Since I don't work there (R1's hallway) very often I thought it (R1's bruise) had been there. (R1) didn't complain of pain or discomfort. We told (E7) (Director of Alzheimer's unit) at that time." E18 stated that, "If the bruise was new then I would have written an incident report. You can look in the incident reports in the computer to see if one was done for a bruise." E18 verified that E18 did not look to see if an incident report had been written or an investigation had been conducted for R1's bruise.</p> <p>An employee schedule dated 6-28-13 to 7-08-13</p>	F9999			

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F9999	<p>Continued From page 44</p> <p>documents that E18 (Licensed Practical Nurse) had worked as the nurse in R1's hallway 6/28, 6/29, 7/01-7/03, 7/06-7/07/2013.</p> <p>On 9-23-13 E13 (Licensed Practical Nurse) stated that on 7-04-13 E13 was informed that R1 had a bruise, stating, "I didn't know if it was a known bruise. I assumed it (the bruise) was because it was yellow." E13 confirmed that E13 did not document on an incident report that R1 had a bruise and did not investigate the cause of R1's bruise.</p> <p>An employee work schedule dated 6-28-13 to 7-08-13 documents that E13 (Licensed Practical Nurse) had worked as the nurse in R1's hallway 6/29, 6/30, and 7/4/2013.</p> <p>9-24-13 at 11:15a.m. E15 (Certified Nurse Aide) stated that E15 had reported R1's bruising to the right groin on three separate occasions. E15 stated that R1, "...doesn't talk much," but that R1 was able to communicate being in pain. E15 stated, "I don't remember the date but the first nurse I told was (E12 Licensed Practical Nurse) and (R1) was complaining of pain." E15 stated that R1's bruise was inside R1's right leg and was light purple. E15 stated that the next time E15 worked E15 reported R1's bruise a second time. E15 stated that R1's bruise "was bigger" and had spread to, "the right side of the vagina and leg and was purple." E15 stated that the E15 reported R1's bruise the second time to E27 (Licensed Practical Nurse). E15 stated that the third time E15 reported R1's bruise was to E28 (Licensed Practical Nurse) which was sometime around 7-06-13. E15 stated that R1's bruise was, "...dark purple and had spread almost to the back of (R1's) leg." E15 stated that R1's bruise had</p>	F9999			

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F9999	<p>Continued From page 45</p> <p>not been reported to E15 by any other staff member during the shift to shift report but that E15 did, "pass it on to the next CNA (Certified Nurse Aide)" who worked on the next shift. E15 stated that E15 had overheard E28 (Licensed Practical Nurse) reporting the bruise to E13 (Licensed Practical Nurse) who was the nurse coming on duty to relieve E28.</p> <p>On 9-24-13 at 3:00p.m. E10 (Licensed Practical Nurse) stated that on either 7-06-13 or 7-07-13, E10 was working as a new nurse in orientation with E19 (Registered Nurse). E10 stated that E29 (Certified Nurse Aide) had reported that R1 had a bruise to the right leg. E10 stated, "It was purple. (E19) went to investigate," and report the bruise. E10 stated that R1's bruise was, "purple and started at the groin and down to the labia of the vagina and with bruising to the mid thigh. It looked somewhat new."</p> <p>On 9-24-13 at 11:45a.m. E19 (Registered Nurse) stated that once E29 (Certified Nurse Aide) notified E10(Licensed Practical Nurse) and E19 of R1's bruise, E19 first looked through R1's shower sheets to see if the bruising had been documented as part of a skin assessment. E19 then called E16 (Director of Care Delivery) to report the bruise. E19 stated that, "(E16) just said 'OK'. He didn't ask me to write an incident report." E19 stated that E19 did not check to see if an incident report had been written to document that R1's bruising had been investigated.</p> <p>On 9-24-13 at 10:50a.m. E16 (Director of Care Delivery) stated that when E19 (Registered Nurse) reported R1's bruising during the weekend of 7-06-13 to 7-07-13, E16 stated that E19 was instructed to write an incident report.</p>	F9999			

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F9999	<p>Continued From page 46</p> <p>E16 stated that before ending the conversation with E19, E19 said, "it looked like it was already taken care of." E16 stated that on 7-08-13 R1's bruise was mentioned to all staff who attended morning rounds including E7 (Director of Arcadia Alzheimer's unit) who was the director over the hallway where R1 resided. E16 stated that, "Apparently the information went to (E7)...If (E7) is handling the investigation then we don't assist unless (E7) needs it."</p> <p>On 9-23-13 at 10:00a.m. E7 (Director of Arcadia Alzheimer's Unit) stated that E7 has education in Social Services. E7 stated that although E7 is the Director of the Alzheimer's Unit, E7 relies on the facility's Director of Care Delivery (E16) who is a nurse to address care issues that require nursing knowledge. On 9-24-13 at 8:45a.m. E7 stated, "The day (R1) went to the hospital (7-08-13) is the first time I had heard of (R1) having any bruising." E7 stated that on 7-08-13, "(E29) (Certified Nurse Aide) came to me with a concern with (R1's) bruising. I went down and (E29) showed me," R1's bruising. E7 stated, "I went and got (E2 Director of Nurses). The bruising was pretty significant. You could tell there was a problem."</p> <p>On 9-23-13 at 4:15p.m. E2 (Director of Nurses) stated that when E7 (Director of Arcadia Alzheimer's Unit) informed E2 of R1's bruising, "I went down and assessed (R1)". E2 stated that R1's right leg appeared shorter than the left leg. E2 stated that R1's leg looked fractured. E2 stated that after an Xray was performed on R1, R1 was transferred to the hospital with a diagnosis of a right fractured femur which required surgery. E2 verified that there was no incident report documenting R1's bruising, and</p>	F9999			

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F9999	<p>Continued From page 47</p> <p>there was no investigation into R1's injury of unknown source prior to 7-08-13</p> <p>On 9-24-13 at 9:00a.m. E2 (Director of Nurses/Abuse Coordinator) stated that, "If staff see a bruise (on a resident) even if it looks like it's been there, they should check to see if it had been documented. Then report the bruise to the abuse coordinator (E2), which wasn't done for R1 until 7-08-13." E2 stated, "I thought this (R1's bruising, fracture, delay in treatment) was going to be a problem." E2 stated that once E2 assessed R1's bruising and right leg, E2 notified E1 (Administrator) of the incident.</p> <p>A facility policy on using a Mechanical Lift for Resident Transfer dated 3/2010 documents the purpose for using a mechanical lift is, "To move immobile or obese patients for whom manual transfer poses potential for staff or patient injury."</p> <p>A facility on Change in Condition: When to Report to the MD/NP/PA (Medical Doctor/Nurse Practitioner/Physician's Assistant) dated 2011 documents to notify the Medical Doctor, Nurse Practitioner, Physician's Assistant immediately with, "any symptom, sign or apparent discomfort that is : Acute or Sudden in onset, and: A Marked Change (i.e. more severe) in relation to usual symptoms and signs..."</p> <p style="text-align: right;">(B)</p>	F9999			