

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004279	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTH-SPRINGFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH RUTLEDGE SPRINGFIELD, IL 62702
--	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Final Observations</p> <p>STATEMENT OF LICENSURE VIOLATIONS</p> <p>300.1210b)4) 300.1210d)3) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care</p> <p>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:</p> <p>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.</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,</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004279	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTH-SPRINGFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH RUTLEDGE SPRINGFIELD, IL 62702
--	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 1</p> <p>seven-day-a-week basis:</p> <p>3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and 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>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>THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: Based on interview, observation and record review, the facility failed to provide eating assistance and develop an individualized plan to increase nutritional intake for eating for 1 of 5 residents (R17) reviewed for nutritional risk and assistance in eating in a sample of 24. This failure resulted in R17 going from 98.2 pounds on admission 2/25/14 to 90.0 pounds on 5/5/14, 8% loss within 3 months.</p> <p>Findings include:</p> <p>The Admission Sheet identifies R17 as being admitted to the facility on 2/25/14 from the hospital with a diagnoses of Protein/Calorie Malnutrition in part. According to the Minimum Data Set (MDS) dated 3/23/14, R17 requires moderate assist of one staff for eating. The Physician's Order Sheet (POS) for May 2014 documents that she is to receive a regular diet and Med Pass 120cc TID (Three times per day) and Magic Cup Supplement BID (twice daily) and</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004279	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTH-SPRINGFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH RUTLEDGE SPRINGFIELD, IL 62702
--	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 2</p> <p>receives Remeron 30mg at bedtime as an appetite stimulant. The care plan 3/10/14 identifies R17 to be a nutritional risk due to debility, appetite only fair, dementia with impaired cognition. Admission weight recorded in care plan as 98.2 pounds. Goal is to gain 3 pounds with interventions to assess weight monthly, diet per orders, encourage fluids - observe for signs of dehydration, if appetite is consistently less than 75% or in need of additional calories/protein, consult dietician, offer substitutes for consistently uneaten foods, attempt to educate resident on consequences of not eating/drinking adequate amounts and refer to dietician for evaluations and recommendations. The care plans do not include either the Med Pass or Magic cup or the assistance required to eat as identified by the MDS. There are no current Albumin or Protein levels in the clinical record.</p> <p>On 5/23/14, R17 was in the television room or dining room from after breakfast until 12 noon. No supplement and/or fluids were offered during this constant observation period of time. A supplemental cup was noted to be sitting on her overbed table in her room mid morning. At lunch meal, R17 was given a glass of Med Pass by the nurse prior to her meal being served. She drank 100% of it. At 12:25pm, R17 was sitting at the table with her head laying on the table asleep. At 12:30pm, her meal tray was served. She had a glass of red drink and water, fish, potatoes and cucumber salad. No assistance and/or cueing/encouragement was provided and staff left the table after setting her meal up. At 12:43pm, R17 was sitting with her head in her hands and had eaten very little. At 1pm, E4 cued R17 to eat once. At 1:15pm, E14, Nurse Manager sat down at the table to assist a table mate but also provided no cueing and/or encouragement to R17</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004279	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTH-SPRINGFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH RUTLEDGE SPRINGFIELD, IL 62702
--	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 3</p> <p>to continue to eat and/or drink. R17 was noted to eat less than 25% and only bites of some of the food items. She appeared to either sleep and/or look about. At 1:30pm, R17 was in the television lounge area. Her Magic cup was sitting in her room on her overbed table with the spoon in it. At 2pm, she was taken to her room to lay down. E8 and E9 transferred her to the toilet then laid her down. At laying her down, E9 asked if she wanted her "ice cream" referring to the Magic Cup and she stated "no."</p> <p>On 5/27/14 at 12:15pm, R17 was in her room at bedside with her food tray on the overbed table in front of her. She had pushed herself away from the table. She had a full glass of Med Pass on her tray. Her meal consisted of meat, cabbage, potatoes, and a piece of cake. At 12:30pm, R17 remained pushed away from her meal tray with no staff in attendance to cue and/or encourage her. At 12:45pm, she remained sleeping and slumped over in her chair. At 1:10pm, R17 was still sleeping with her food in front of her. E24, CNA walked by, stated "She needs a straw in her glasses" and entered the room to assist her, approximately an hour after her meal was delivered. At 1:50pm, E24 stated in interview that R17 ate only about 25%. Her Med Pass was not consumed.</p> <p>According to the Nutritional Intake Flowsheet for May 2014, R17 is recorded as routinely only eating 25% of her lunch meal and the majority of her supper meals. Breakfast is recorded between 25% and 50% with most at 50%. Fluids are recorded to be 180cc at breakfast, 120-180ccc at lunch and 75-240cc at supper.</p> <p>Weight records show R17 weights as follows: 2/25/14 - 98.2 pounds (#), 3/6/14 - 97.2 #,</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004279	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/30/2014
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTH-SPRINGFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH RUTLEDGE SPRINGFIELD, IL 62702
--	--

(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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 4</p> <p>3/20/14 - 92.4#, 4/2/14 - 90.6 and 5/5/14 - 90.0. A Registered Dietician's (RD) Note dated 4/14/14 identifies her weight on that date at 91# with a 7% weight loss over 30 days. Remeron increased for appetite increase, HP ice cream also given, nut support given continue to monitor, rec (recommend) ^ (increase) supplement due to weight loss. The RD assessment dated 3/4/14 identifies R17's minimum daily fluid requirements as 1336ml/24 hours. There has no been revision of the plan of care for R17 since her additional weight loss and the current care plan fails to reflect R17's individualized needs.</p> <p>On 5/27/14 at 1:50pm, E13 Licensed Practical Nurse (LPN) was asked for documentation for consumption on the med pass and/or magic cup and stated they don't keep track of what they consume. E13 stated they document that the Med Pass is given on the Medication Administration Record (MAR) and will document refusals but don't document amount or % consumed.</p> <p>On 5/30/14 at 9:45am, E24 CNA stated in interview that R17 eats much better in her room away from the distractions with a one on one feeding her. E24 stated she has fed her several times this week and R17 has done well with allowing assistance.</p> <p>(B)</p>	S9999		
-------	--	-------	--	--

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145229	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE HEALTH-SPRINGFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH RUTLEDGE SPRINGFIELD, IL 62702
--	--

(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	<p>INITIAL COMMENTS</p> <p>Annual Recertification and Licensure Survey</p> <p>Complaint Investigation # 1442309 (IL 70025) - No deficiencies</p>	F 000		
-------	---	-------	--	--

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.