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	145038	A. BUILDING ______ B. WING ______	C 07/08/2014

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HEARTLAND OF DECATUR	444 WEST HARRISON STREET DECATUR, IL 62526

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F 000	INITIAL COMMENTS Complaint Investigation 1462724/IL70494- no findings 1462785/IL70559-F309 1462763/IL70534-F323, F315	F 000		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide treatment and services to promote healing and prevent infection for post surgical wounds resulting in infection and requiring additional hospital treatment. This affects one of three residents (R2) reviewed for wound treatments in a sample of six. This past noncompliance occurred from 5/9/14 to 5/23/14. Findings include: The Admitting Record documents R2 was admitted to the facility on 5/2/2014 with diagnoses to include a fracture of the tibia and fibula. The hospital History and Physical dated 4/26/14 by Z1 (Physician), documents R2 required surgical repair of the distal tibia and fibula fracture. The hospital Discharge Instructions dated 5/2/14,	F 309	Past noncompliance: no plan of correction required.	

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.

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F 309	Continued From page 1 document to leave R2's dressing in place for one week then change to a dry dressing daily and as needed. The facility Admission Physician Orders for R2 dated 5/2/14, documents to leave the dressing in place for one week then clean the area with wound cleaner and put a dry dressing on daily and as needed. The Administration Record dated 5/9/14 through 5/18/14, documents only one dressing change on 5/12/14. On 7/3/14 at 2:40pm, E6 (Nurse), stated R2's staples were removed and the wound to the right lateral ankle was cleansed and dressed on 5/12/14. The Physician Visit Report by Z1 dated 5/19/14, documents R2 presenting with "an extremely dirty dressing. It was soaked with purulent drainage." A foul odor was present with drainage from the incision at the lateral ankle and it was documented as infected. The report documents Z1 reported the condition of the wound to the facility. Z1 documents an incision and drainage and antibiotics are needed to treat the wound. The facility Progress Notes, 5/20/14, documents R2 was discharged to home. The hospital Report of Operation dated 5/21/14, documents R2 with a right lateral ankle post surgical infection. A right lateral ankle incision and drainage and placement of a vac dressing was performed. R2 was discharged from the hospital on 5/23/14. On 7/1/14 at 1:53pm, E1 (Administrator) that E2 (Director of Nursing) contacted E1 to report Z1's	F 309		

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F 309	Continued From page 2 concern with R2's when Z1 called the facility on 5/19/14. E1 completed an investigation and the facility identified the Administration Record lacked documentation of the dressing changes being completed. The nurses were interviewed, and except for 5/12/14, the facility could not confirm dressing changes were completed as ordered by the physician. On 7/1/14 at 4:30pm, Z1 confirmed that R2 was discharged to the facility with staples to the surgical areas. When R2 presented to the office on 5/19/14 the wound to the right lateral ankle was covered with two dressings and a lot of discharge. The dressing was dirty and the wound odorous. Z1 contacted the facility to report the concerns. After discharge from the facility, R2 required an incision and drainage to clean out the wound, antibiotics and further wound care due to an infection most likely from lack of wound care while residing at the facility. Z1 stated the dressing should have been changed more timely while R2 was at the facility, and that may have prevented the infection or at least identified the infection sooner. On 7/1/14 at 2:46pm E2 stated that lack of documentation on the Administration Record indicates either the treatment wasn't completed or the nurse failed to document the completion of the treatment. All treatments are to be provided per the facility policy for medication administration. Nurses are to follow physician orders. The facility policy for General Dose Preparation and Medication Administration dated 5/1/13, documents that nurses are to document necessary treatment information.	F 309		

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F 309	Continued From page 3 The surveyor confirmed by interview and record review thats the facility identified the noncompliance with R2's dressing changes during and investigation and placed an action plan in place on 5/20/14. The action plan included reporting the incident to the state agency, review all treatment administration records a the facility, residents with identified omissions on the treatment record were re-assessed, and nursing education on skin practice guidelines, documentation guidelines, and staff communication. In addition the facility identified resident who have the potential to be affected and conducted a skin sweep, validated treatment orders, and ensured skin alteration records and care plans were in place for residents with treatment orders. Monitoring was placed and continues to be completed by administrative personnel, including review of daily progress notes, communication tools, and random treatment administration audits. A Quality Assurance Committee was conducted on 5/20/14 with weekly committee monitoring for four weeks. This action plan was initiated on 5/20/14 and completed on 5/23/14.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		

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F 315	Continued From page 4 function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to promptly collect a urine specimen as ordered for potential urinary tract infection for one of three residents (R3) reviewed for urinary tract infections in a sample of six. Findings include: The hospital transfer records document R3 discharged to the facility on 1/24/14 with a history of urinary tract infections. A hospital urine culture dated 2/1/14, documents R3 with a Vancomyacin Resistant Entercoccal Urinary Tract Infection. The Physician Order Sheets dated 4/22/14, document an order to obtain a urinalysis and a urine culture and sensitivity. The facility Progress Notes, 4/22/14 through 4/23/14, do not document the reason for the urinalysis order or attempts to obtain the specimen. The facility Progress Notes dated 4/30/14, documents R3 with increased confusion. This note documents, "(R3) has an order to get a urinalysis done and this writer asked the MD for orders to straight cath (R3)." The laboratory report dated 5/1/14, documents a urinalysis and urine culture was obtained on 4/30/14. On 7/8/14 at 1:55pm, Z4 (Physician), stated R3 had a history of recurrent urinary tract infections. Z4 did not recall why the 4/22/14 ordered was written, but R3's family may have requested the test.	F 315		

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F 315	Continued From page 5 On 7/8/14, E2, (Director of Nursing), stated a urine sample for testing should be completed within twenty-four hours. If the staff were unable to obtain the specimen the physician should have been contacted. The urinalysis and urine culture ordered by Z4 for R3 should have been completed prior to 4/30/14.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to maintain a safe environment by leaving R3 unattended in the bathroom, and failing to supervise and implement effective fall interventions for one of three residents (R3) reviewed for falls in a sample of six. This failure for R3 resulted in fractured fibula requiring hospital treatment. Findings include: 1. The hospital Discharge Summary, 1/24/14, documents R3's discharge to the facility was delayed due to a fall at the hospital on 1/23/14. R3 was transferred to the facility on 1/24/14. The facility Admission Record dated 1/24/14, documents R3 with diagnoses to include	F 323		

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dementia, abnormal gait, muscle weakness and convulsions. R3's Admission Screening, 1/24/14, documents R3 with moderately impaired cognition and at risk for falls due to a history of falls, muscle weakness, incontinence, psychotropic medication use, and other underlying health conditions. The facility kardex and careplan dated 1/24/14, documents R3 as at risk for falls, with interventions including a low bed, meals in the dining room, have commonly used articles within reach, and toilet before bed.

The facility Incident Report dated 2/6/14 at 11:00pm, completed by E9 (Nurse) documents R3 as being found on the floor by E5 (Nursing Assistant). The Statement, 2/6/14, by E5 documents "I went to answer the call light and I observed (R3) on the floor by the bed and commode." Another Statement by E5 on 2/12/14, documents "I put R3 on the commode and (R3) had her call light. . ." E5 went to assist another resident and when E5 returned R3 was on the ground. The Progress Note, 2/6/14, completed by E9 documents R3 was sent to the emergency room. The hospital emergency room report, 2/6/14, documents R3 with a fracture to the left distal fibula and a splint was applied.

On 7/8/14 at 11:35am, E9 stated R3 was placed on a commode by E5 on 2/6/14. R3 was asked to wait for assistance. R3 attempted to transfer without assistance and was found on the floor by E5. R3 was confused and a fairly new admission to the facility. E9 stated residents with cognitive deficets should not be left unattended on the commode.

On 7/3/14 at 2:31pm, E5 stated R3 had activated the call light. E5 answered the light and assisted

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R3 to the bedside commode. E5 stated R3 was left on the commode alone to assist another resident who was a fall risk. While E5 was assisting the other resident R3 fell trying to transfer back to the bed without assistance. E5 stated residents at fall risk are not to be left alone on the commode. E5 stated nursing assistants identify residents at risk for falls on the kardex. E5 stated she was unaware R3 was at risk for falls at the time of the fall on 2/6/14.

The facility Investigative Report of R3's fall on 2/6/14, completed on 2/13/14, documents a conclusion as R3 was found on the floor in room after trying to self transfer from a bedside commode. R3 has multiple risk factors. R3 will be assisted to and from the commode for safety.

On 7/8/14 at 1:20pm, E2 (Director of Nursing) stated after the fall on 2/6/14 the intervention placed was to assist R3 when using the commode. E2 stated the intervention placed to assist R3 on and off the commode was a practice which should have been followed by E5 at the time of R3's fall on 2/6/14. R3 should not have been left alone on the commode. E2 could not provide the reason E5 left R3 alone on the commode.

On 7/8/14 at 1:55pm, Z4 (Physician), stated R3 staff should try not to leave residents alone on the commode. Z4 also stated that in order to keep R3 safe she would need to remain one to one with staff and that was not possible.

2. The facility Incident Report, 3/20/14 at 5:30pm, documents R3 with an unwitnessed fall. The Investigative Report, 3/2014, documents R3 was last observed by staff eating dinner twenty

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minutes before the fall. The intervention placed was to assist R3 to the bed after the evening meal.

On 7/8/14 at 1:20pm, E2 (Director of Nursing) stated R3 was to be assisted back to bed after the evening meal. R3 was last observed 20 minutes before the fall eating dinner in the bedroom. E2 could not indicate how this would be effective since R3's last observation by staff was when R3 was eating dinner.

3. The facility Incident Report, 3/22/14 at 10:40pm, completed by E12 (Nurse), documents an unwitnessed fall; R3 was found on the floor in the bedroom. R3 reported she was trying to go to the bathroom and slipped. The intervention documented by E12 at the time of the fall was the bed was placed in low position. The Investigative Report, 3/24/14, documents toilet R3 before bed as an added intervention.

On 7/3/14 at 12:10pm, E2 stated the last time R3 was taken to the bathroom prior to the fall is not known and not documented. On 7/8/14 at 1:20pm, E2 could not indicate if R3's bed was already in low position per the plan of care at the time of the fall on 3/22/14. E2 could not provide information as to why E12 lowered the bed after the fall when the low bed was an intervention in place at the time of the fall.

The facility policy, Fall Practice Guidelines, 2011, documents approaches are selected based on the patient's preferences, risk factors, co-morbid conditions, and willingness to participate with the plan of care. The approaches for fall interventions are clear specific and individualized for the patient's needs.

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