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	145038	A. BUILDING _____ B. WING _____	11/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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	INITIAL COMMENTS Annual Licensure and Certification Survey Complaint #1264021 / IL 60327 -No Deficiency Complaint #1264223 / IL 60547 -No Deficiency Validation Survey for Subpart U: Alzheimer Unit Heartland of Decatur is in substantial compliance with Subpart U, 77 Illinois Administration Code 300.7000.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225		12/26/12

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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violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to report an allegation of verbal abuse to the Administrator immediately after the alleged abuse occurred, for R3. R3 is one of one resident reviewed for an allegation of abuse in a sample of 21.

The finding includes:

During review of the facility's abuse allegation investigations, a verbal abuse allegation was reported on 5-4-12. The report stated "over the course of the last month or so CNA (Certified Nurse Assistants E10 and E11) have been saying mean things to (R3). (R3) constantly asks "Where's my husband" on multiple occasions (E11) has whispered in her ear "(spouse) is home with me. I'm f---ing your husband. (spouse) is at my cousin's house". (E10) also says things just like that sometimes it makes her cry."

The Administrator, E1 stated on 11-28-12 at 9:45 A.M. that E9 (CNA) reported the allegation. E1

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F 225	Continued From page 2 stated that E9 delayed in reporting the allegation to the Abuse Coordinator. The 5-4-12 investigation report stated that E9 said "I knew it was abuse. -------- I did not report it because I was hoping someone would hear them say it."	F 225		
F 246 SS=C	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that water available for bathing and handwashing was hot. This failure has the potential to affect all 101 facility residents. Findings include: During the General Observation tour on 11-28-12 between 11:00 A.M. and 12:15 P.M., the hot water temperatures were tested using a calibrated digital thermometer and recorded in resident bathing areas. The Maintenance Director (E12) and the Housekeeping and Laundry Supervisor (E13) was present when the hot water temperature were taken. E12 stated that facility has two hot water distribution systems that provides hot water to all the resident areas. E12 stated he takes the temperatures daily and	F 246		12/26/12

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F 246	Continued From page 3 he has been recording hot water above 100 degrees Fahrenheit (F). at all locations. On 11-28-12 at 11:30 a.m. in the North Central bathing room the shower temperature was 86 degrees F. and the lavatory temperature was 96 degrees F at 11:30 a.m. in North Shower Room. The thermometer on the hot water discharge line recorded 100 degrees F. On 11-28-12 the hot water temperature was 98 degrees F. at the shower and 98 degrees F. at the lavatory in the Annex shower room at 11:45 A.M. The Macadamia shower room shower recorded 97 degrees F. and the lavatory was 98 degrees F. 12:15 P.M. The hot water distribution system for the Annex and Arcadia units did not have thermometers at the discharge to the units. The thermometer on top of the hot water heater recorded 125 degrees before the hot water goes to the mixing valve. The water was allowed to run for 3 minutes before temperatures were recorded. According to the Centers for Medicare and Medicaid Services 672 form completed 11-27-12 there are 101 residents living in the facility.	F 246		
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.	F 323		12/26/12

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to provide supervision to R3 during a catastrophic (significant behavioral) event resulting in R3 slamming her right index finger into another resident's door which resulted in partial amputation of the right index finger. The facility failed to provide safe transfers from a mechanical lift to R6's bed which resulted in R6 sustaining a fractured tibia during the second transfer. R3 is one of three residents reviewed for behaviors in the sample of 21, and R6 is one of 10 residents reviewed for falls and fractures in the sample 21.

Findings include:

1. The Physician's Order Sheet dated November 2012 lists the following diagnoses for R3: Alzheimer's Disease, Dementia with Agitation and Failure to Thrive. The MDS (Minimum Data Set) dated 10/16/12 states R3 is severely impaired in daily decision making skills, and displays physical and verbal behaviors which occur on a daily basis and impact both R3 and other residents.

The facility's report titled "Incident Report-Patient Involved" dated 3/18/12 documents R3 had an incident on 3/18/12 at 6:45 PM under the section titled "Incident Description and Investigation". This section states R3 was standing at another residents' door attempting to push the door open and a CNA (Certified Nursing Assistant) was trying to redirect R3 away from the door. When the CNA approached the door R3's right index

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finger was in the door bleeding and injured. The facility's form titled "Witness Statement" by Z3, Daughter of R31, states Z3 was putting her mother to bed and R3 came into R31's room stating R3 needed to talk to Z3 and wanted Z3 to help R3. Z3 told R3 she could not help her and would need to go to the nurses station to call R3's husband. R3 started to leave R31's room, changed her mind, and headed back into R31's room. Z3 closed the door. R3 pushed the door open and stated to Z3 to not close the door in her face. Z3 tried to hold the door closed. R3 reached in and smacked Z3's face. Z3 stated she yelled for help (no staff was available) and pushed the door closed. R3 pushed the door open again not knowing R3's finger was in the door. The Facility's Witness Statement by E17, LPN (Licensed Practical Nurse), states " (R3) was on the locked Alzheimer's unit due to some increased behaviors.....Around 6:30 PM I exited the Alzheimer's unit with (R3) to take her to her room to lay down and provide 1 to 1.....While walking to (R3)'s room (E17) stopped to give (R31's) her medication.... (E17) went to the nurses station to take a long distance phone call from a family member who had been waiting for 20 minutes. (E17) took the phone to another resident's room and was gone for approximately 2-5 minutes and (E17) saw (R3) standing up in front of (R31's) room with (R3's) hands up to the door...when (E17) got to the door (R3's) finger was in the door and blood everywhere."

E1, Administrator stated on 11/29/12 at 1:50 PM "My understanding of the incident is (R3) was following the nurse (E17) with medication pass. (E17) received a phone call and (E17) decided to take the phone call and (R3) was left alone for a short period of time.....(E17) made a judgement

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call to take care of the phone call and was gone. (R3) was not on a formal one to one status but (R3) was to be in a common area to be able to be more supervised and monitored."

The Hospital Report titled "Emergency Room Document" dated 3/18/12 states "Diagnosis" "Final: Right Index Finger Partial Amputation, Additional: Nail Plate and Nail Bed Avulsion Right Index Finger, Open Distal Phalanx Fracture Right Index Finger."

2. The Physician Order Sheet dated 11/12 for R6 documents reflects the following diagnoses: Infantile Cerebral Palsy, Scoliosis, Asthma, Speech Disturbance, Gastroesophageal Reflux Disease, Tracheostomy, Gastrostomy, Spinal Fusion and Constipation.

The Minimum Data Set for R6 dated 11/9/12 documents R6's functional status for transfers as total dependence, using full staff performance.

A. The Facility's report titled Incident Report - Patient Involved dated 1/27/12 for R6 documents a transfer involving R6 with a mechanical lift. According to the report during the transfer to R6's bed, E15 and E16 (Certified Nursing Assistants) lowered R6's bed and did not move R6's feeding pump from the downward path of the bed, causing the feeding pump to fall and strike R6 across her left cheek.

On 11/29/12 E2 (Director of Nursing) at 11:00 a.m. acknowledged that E15 and E16 (Certified Nursing Assistants) were interviewed about the incident and should have placed the feeding pump out of the way before lowering the bed during the transfer of R6.

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B. Nursing Notes signed by E21 (Registered Nurse) dated 1/29/12 document that during care R6 was noted to have a discoloration on her left knee and left ankle, and was sent out to the Emergency Room for evaluation and treatment. R6 returned 1/29/12 with a brace on her left leg and a diagnosis of acute Left Proximal Tibia Fracture.

The Facility Incident Report - Patient Involved dated 1/29/12 for R6 documents an investigation into the discoloration of R6's left knee and ankle. The investigation concludes that during a transfer with a mechanical lift on 1/28/12, E7 and E8 (Certified Nursing Assistants) did an improper transfer that caused R6 to sustain an acute left proximal tibia fracture.

On 11/29/12 E1 (Administrator) at 11:40 a.m. stated that E7 and E8 (Certified Nursing Assistants) were terminated for their actions during the 1/28/12 transfer of R6.

C. The Facility's report titled Incident Report - Patient Involved dated 2/14/12 for R6 documents that R6's arms were not safe guarded by E19 and E20 (Certified Nursing Assistants) during a mechanical lift transfer. R6's right arm flung out involuntarily and her right hand was caught under the bar of the mechanical lift when she was being lowered, causing bruising and swelling.

On 11/29/12 at 11:00 a.m. E2 (Director of Nursing) acknowledged that E19 and E20 (Certified Nursing Assistants) should have safe guarded R6's arms and had performed an improper transfer, resulting in a bruised and swollen right hand.

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F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on interview and observation the facility failed to maintain equipment in a clean and sanitary manner to avoid cross contamination during food preparation or meal service. The facility failed to maintain the walk in freezer and walk in cooler to avoid overhead water contamination of food stored underneath the condenser. Knives, serving utensils, and preparation utensils were not cleaned or well maintained in a smooth easily cleanable condition. This has the potential to affect all 101 residents. Findings include: 1. On 11-27-12 at 2:00pm with E3, Dietary Manager (DM) the walk in freezer was identified to have a dripping area from the overhead condenser line directly over an open box of ham patties. The back wall of the freezer area had an ice buildup that E3 stated she was unaware of which had built up behind the condenser along the wall.	F 371		12/26/12

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2. On 11-27-12 at 9:50am with E4, Assistant Dietary Manager, the walk in cooler was identified to have a water drip coming down from the condenser line directly over food stored on shelving. A pan with Sweet Potato Casserole was directly under the condenser line and two puddles of water had collected on the foil lid covering the pan. E4 stated she was unaware of this drip.

3. On 11-27-12 at 1:55pm with E4 four of 6 knives had dried on food debris present.

4. On 11-27-12 at 1:55pm with E4 the storage of utensils resulted in 2 serving scoops and 1 gravy ladel that had dried food debris in the metal bowl portions of the utensils. There were 7 of 8 bowl scrapers that had rough broken edges that were no longer easily cleanable.

5. On 11-27-12 at 2:30 pm the can opener blade surface had a dark thick build up on the upper 1/8 inch of the blade near the metal housing.

According to the Centers for Medicare and Medicaid Services 672 form completed 11-27-12 there are 101 residents living in the facility.