STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145021	A. BUILDING _____ B. WING _____	11/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND OF MACOMB	8 DOCTORS LANE MACOMB, IL 61455

(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.	F 000		
F 323 SS=D	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 record review and interview, the facility failed to ensure the safety of a resident with suicide ideation and previous suicide attempts for one (R24) of one residents reviewed with suicide ideation in a total sample of fifteen. Findings Include: The "Nurse's Notes" [for R24], dated 05/28/2015, at 3:45 a.m., document that E3 (Registered Nurse) was notified that R24 was found, in R24's room, with the bed control/call light cord wrapped around R24's neck. E3 and E4 (Registered Nurse) assessed R24 and instructed staff to "remove items from room and watch [the] resident". The "Nurse's Notes" [for R24], dated 05/28/2015, at 4:15 a.m., document that E3 entered R24's room [after initially assessing R24 during the 05/28/2015, 3:34 a.m. incident] and found R24 with the "clear, plastic, oxygen, supply bag over	F 323		

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 323	Continued From page 1 [R24's] face". On 11/4/2015, at 2:40 p.m., E3 stated: 1) "No one was with [R24] at that time [of the 05/28/2015; 4:15 a.m. incident].....I am pretty sure [R24] did not have a call light due to the previous attempt"; 2) "I would have expected staff (Certified Nurse's Assistants) to have remained in the room with R24 at all times"; 3) "The oxygen bag was right next to the bed, with in [R24's] reach, and I would have expected that they (Certified Nurse's Assistants) would have removed it from the room"; 4) R24 had "red marks" on R24's neck after R24 wrapped cord around R24's neck during the first suicide attempt; 5) after R24's second attempt, with the oxygen supply bag, R24 was "unresponsive to verbal stimuli for less than five minutes"; and 6) after E3 administered oxygen to R24, R24 "came around and started to talk and respond per "[R24's] normal neurological status". On 11/4/2015, at 10:00 a.m., E1 (Administrator) stated, "It would be my expectation that the staff insist the resident went to the emergency room....it would also be my expectation that someone stay with the resident, one on one, until they are transported to the emergency room." On 11/4/15, at 11:37 a.m., Z1 (Medical Director) stated, "In my professional opinion, if a resident attempts suicide, someone should stay with the resident one on one at all times until that resident is transported to the emergency room."	F 323		