STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146030	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CHRISTIAN VILLAGE	101 TROWBRIDGE ROAD NEOGA, IL 62447

(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	F 000		
F 225 SS=D	Annual Licensure and Certification Survey 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 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	F 225		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146030	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CHRISTIAN VILLAGE	101 TROWBRIDGE ROAD NEOGA, IL 62447

(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 225	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review facility staff failed to immediately report an allegation of verbal abuse to the Administrator/Abuse Coordinator for one of 15 residents (R3) on the sample of 15. Findings include: On 8/7/14 at 12:20pm E9, Activity Aide stated she witnessed verbal abuse involving R3 and E8, CNA(Certified Nurse Aide). E9 stated she heard E8 tell R3 she had to stay in the sun room because R3 couldn't be in her room by herself. E9 stated she was ok with that part of the conversation, but then E8 told R3, "You take a lot of work and I don't have time for you!" E9 stated she thought the last part of E8's conversation with R3 could be verbally abusive. E9 stated she immediately reported the allegation involving E8 and R3, to E6 LPN (Licensed Practical Nurse). E9 stated she thought E1, Administrator was not in the building and did not report the incident to E1. E9 stated the incident happened about a month ago and she thought it was in the afternoon before the 4:00pm meal, but could not give a specific date/time. On 8/7/14 at 12:55pm E6, LPN stated she did not remember E9 reporting any allegation of verbal abuse to her, relating to R3 and E8. On 8/7/14 at 12:30pm E1, Administrator confirmed that he was not aware of an allegation	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146030	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CHRISTIAN VILLAGE	101 TROWBRIDGE ROAD NEOGA, IL 62447

(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 225	Continued From page 2 of verbal abuse involving R3 and E8. E1 stated all allegations of abuse are to be reported to him immediately. E1 stated he would have suspended E8 and started the investigation to determine whether abuse occurred or not, if the allegation had been reported to him. E1 stated that E9 should know to report allegations to him (E1) immediately, including calling when he's out of the building. The facility policy "Prevention of Abuse dated 10/29/10 states, "When staff are aware of any type of abuse, such as witnessing or hearing any action, that could constitute abuse . . . .they are to report it to the Abuse Coordinator. . . . .Staff members . . . . are obligated to report . . . . witnessed abuse to the Administrator (who serves as the Abuse Prevention Coordinator) immediately . . . .so the matter can be investigated and the resident be safeguarded against further threats to . . . .emotional well-being. . . . .Verbal abuse is defined as the use of oral . . . .language that willfully includes disparaging and derogatory terms to residents . . . . regardless of their. . . .ability to comprehend . . ."	F 225		
F 309 SS=D	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	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146030	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CHRISTIAN VILLAGE	101 TROWBRIDGE ROAD NEOGA, IL 62447

(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 309	Continued From page 3 by: Based on record review and interview the facility failed to provide necessary services to promote healing by failing to conduct a nutritional assessment for one of two residents (R13) reviewed for vascular ulcers on the sample of 15. Findings include: The Electronic Medical Record dated August 2014 documents R13's diagnoses include Diabetes, Chronic Kidney Disease State V, and Acute Kidney Failure. The Care Plan dated 5/15/14 documents "Dietary consult for nutritional regimen and ongoing monitoring." The Wound Assessment Reports dated 6/6/14 and 8/6/14 document R13's wound on left second toe measured 1.1 centimeter (cm) by 1.1 cm and 1.0 cm by 1.1 cm, respectively. The Physician Notification Note dated 8/6/14 documents "Resident has area on left second toe that has not healed at this time." Telephone Order dated 8/6/14 documents an order for R13 to receive Decubi-Vite Capsule (Multiple Vitamins-Minerals) give one capsule by mouth in the morning for altered skin integrity. On 8/6/14 at 10:08 am and 8/7/14 at 9:40 am E2, Director of Nursing confirmed that R13 has an unavoidable vascular ulcer on her left second toe, which was first identified on 6/6/14. E2 stated that she failed to notify Z3 (Registered Dietitian) of the development of R13"s ulcer. E2 confirmed that no nutritional assessment was conducted for R13's wound.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146030	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CHRISTIAN VILLAGE	101 TROWBRIDGE ROAD NEOGA, IL 62447

(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 315	Continued From page 4 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 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide correct incontinence care technique to prevent Urinary Tract Infections for one of five residents (R4) reviewed for incontinence care on the sample of 15. Findings include: On 8/4/14 at 3:05 pm E5, Certified Nursing Assistant (CNA) provided incontinence care for R4 with E4, Registered Nurse assisting. E5 wiped stool from R4 ' s rectal area with a " back-to-front" motion four times. On 8/4/14 at 3:20 pm E4 stated that incontinence care should always be performed with a "front-to-back" motion.	F 315		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146030	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CHRISTIAN VILLAGE	101 TROWBRIDGE ROAD NEOGA, IL 62447

(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 332	Continued From page 5	F 332		

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and observation the facility failed to ensure a medication error rate below 5%. The facility failed to give medications per pharmacy recommendations, manufacturer's specifications and professional standards for one resident (R2) in the sample of 15 and two residents (R20 and R21) on the supplemental sample. The facility had four medication errors out of 25 opportunities for error resulting in an 16% error rate.

Findings include:

1. On 8/4/14 at 3:30 PM E6 Licensed Practical Nurse administered Simethicone (antiflatulent) 80 milligrams (mg) to R20. At that time Z2 Caretaker stated that R20 had not eaten since 1:00 PM and her next meal would be served at 4:00 PM. The Simethicone packaging states give after meals. The Lexicomp Electronic Drug Reference states that Simethicone should be given after meals.

2. On 8/4/14 at 3:30 PM E6 administered Artificial Tears two drops consecutively in each eye to R20. E6 did not wait the recommended three to five minute between drops. On 8/4/14 E6 confirmed that she did not wait after giving R20 the first eye drop before giving the second eye drop. On 8/6/14 at 11:30 AM E2 Director of Nurses stated that E6 should have waited 30 seconds after instilling the first eye drop before instilling the second eye drop.

3. On 8/5/14 at 12:15 PM E7 Registered Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146030	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CHRISTIAN VILLAGE	101 TROWBRIDGE ROAD NEOGA, IL 62447

(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 332	Continued From page 6 (RN) administered Potassium Chloride Extended Release 20 millequivalents (mEq) to R21 crushed with approximately two teaspoons of pudding and no other food. The medication packaging states "do not crush" and "take with food". The Lexicomp Electronic Drug Reference states Oral Potassium should be taken with meals and also states that Potassium tablets should not be crushed. On 8/5/14 at 12:20 PM E7 confirmed that she crushed the Potassium tablet prior to administering it to R21. E7 also stated that R21 last ate 10:00 AM that morning. 3. On 8/5/14 at 12:25 PM E7 administered Potassium Chloride Extended Release 20 mEq to R2 with eight ounces of water and no food. The medication packaging states "take with food". The Lexicomp Electronic Drug Reference states Oral Potassium should be taken with meals. On 8/5/14 at 12:25 PM E7 stated that R2 had not eaten since 10:00 AM that morning.	F 332		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146030	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND CHRISTIAN VILLAGE	101 TROWBRIDGE ROAD NEOGA, IL 62447

(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 520	Continued From page 7	F 520		

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility quarterly Quality Assessment and Assurance (QA & A) Committee meetings failed to include a Physician in two meetings in the past year. This failure has the potential to affect all 63 residents who reside at the facility.

Findings include:

On 8/6/14 at 2:30 pm E1, Administrator, stated that Z1 (Physician, Medical Director) is on the QA and A Committee. E1 presented the sign in sheets which document signatures of the QA and A committee members in attendance. The sign-in sheets for the QA and A Committee meetings dated 9/18/13 and 12/12/14 do not document the signature of a physician. E1 confirmed that neither Z1 nor any other Physician attended the quarterly QA and A Committee meetings held on 9/18/13 and 12/12/13.

The Residents Census and Conditions of Residents report dated 8/5/14 documents that 63 residents reside in the facility.