STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145961	A. BUILDING _____ B. WING _____	C 11/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEDDINGTON OAKS	**2223 WEST HEDDING AVENUE PEORIA, IL 61604**

(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 Original complaint investigation 1626385/IL89710.	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 record review and interview, facility staff failed to do a physical assessment after a fall for one of three residents (R1) reviewed for accidents/injury in a sample of three. This failure resulted in prolonging the diagnosis of a comminuted, impacted, and displaced fracture of the distal metaphysis with extension to the articular surface [femur] by three days. Findings include: Facility policy, entitled "Falls and Fall Risk", revised April 2007, document, "After a fall: If a resident has just fallen, or is found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injuries to the head, neck, spine, and extremities..." R1's "Physician Order Sheet", dated 11/2016, document R1's diagnosis to include : Dementia,	F 309		

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

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F 309	Continued From page 1 Chronic Kidney Disease Stage 3, and Delirium; Do Not Resuscitate; and Comfort Care. R1's "Brief Interview for Mental Status" [BIMS], dated 9/26/2016, document R1's BIMS as 0 [zero]. R1's "[Facility Name] Interdisciplinary Nursing Notes", document: 1) 11/7/2016 [no time written] Late Entry 11/3/2016. Nurse was notified by CNA [certified nursing assistant] that she [R1] slid out of bed and lowered to floor and noted no injury...facial expressions without and abnormal per CNA; 2) 11/6/2016 2:30 p.m., New Order received X-ray right knee-pain/swelling; 3) 11/6/2016 4:45 p.m., notified of X-ray results, new order received to send resident to local hospital for evaluation; and 4) 11/6/2016 5:35 p.m., Resident transported to local hospital. Local hospital, "ED {Emergency Department] Provider Notes", dated 11/6/2016, at 6:39 p.m., written by Z1 (Emergency Department Medical Doctor) document: "She [R1] has severe dementia and will not voice pain, but she screams if the right leg is touched or manipulated; Diagnosis-Closed displaced comminuted fracture of shaft of right femur." R1 admitted to the local hospital for medical management. Local hospital "Discharge Summary", dated 11/9/2016, at 1:19 p.m., by Z2 (Medical Doctor), document; "...found to have multiple comminuted, impacted, and displaced fractures of the distal right femoral metaphysis, as well as likely patellar fracture. Orthopedic surgery was consulted and advised against operative management. Right lower extremity was unable to be immobilized secondary to lower extremity contracture.	F 309		

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F 309	Continued From page 2 Orthopedics recommended hospice care and palliative care was consulted. Discharged with hospice." On 11/9/2016, at 2:20 p.m., E5 (Certified Nursing Assistant) stated, " On 11/3/2016, I stepped out of [R1's] room to get an incontinence pad and when I came back in the room, [R1] was on the floor. R1's bed was elevated waist high, and E4 (Certified Nursing Assistant) was standing on the opposite side of the bed. [E4] told me [R1] slid out of bed. I reported it to the nurse [E3-Licensed Practical Nurse]. The nurse came in to the room, just looked at [R1] and left the room without assessing [R1]. [R1] screamed when we put her back in to bed. The nurse heard the scream and came and asked [E4] if [R1] always screams like that, in which [E4] replied yes. The nurse did not even put [R1] on fall vitals. I knew something wasn't right when [R1] was eating very little and seemed uncomfortable during the days to follow." On 11/10/2016, at 10:12 a.m., E4 confirmed: R1 fell off the bed; R1's vitals were not assessed; did not recall E3 performing a physical assessment. On 11/10/2016, at 10:23 a.m., E3 stated, "[E4] told me she lowered [R1] to the floor, so she did not consider that a 'Fall'. I do not remember if any vitals were taken. I did not perform any range of motion on [R1], I just touched her shoulders and hips." R1's "[Facility Name] Interdisciplinary Nursing Notes", do not document any information regarding any vitals and documentation of R1 being found on the floor except the "11/7/2016 Late Entry" aforementioned.	F 309		

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F 309	Continued From page 3 On 11/10/2016, at 10:54 a.m., E2 (Assistant Director of Nursing) confirmed E2 expected that R1's vitals should have been assessed, and due to R1's contracture's, a limited range of motion should have been checked by E3.	F 309		
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 record review and interview, facility staff failed to safely reposition one resident of three residents reviewed for accidents/injury (R1) in a sample of three. This failure resulted in R1 being rolled off the side of R1's bed, causing multiple comminuted, impacted, and displaced fractures of the distal metaphysis with extension to the articular surface [femur]. Findings include: Facility policy, entitled, "Positioning and Moving", revised April 2007, document, "Adjust the bed to a comfortable working position; Lower the side rails on the side of the bed you are working; and turn the resident toward you with a turning sheet..." R1's "Physician Order Sheet", dated 11/2016,	F 323		

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F 323	Continued From page 4	F 323		

document R1's diagnosis to include : Dementia, Chronic Kidney Disease Stage 3, and Delirium; Do Not Resuscitate; and Comfort Care.

R1's "Brief Interview for Mental Status" [BIMS], dated 9/26/2016, document R1's BIMS as 0 [zero].

R1's "[Facility Name] Interdisciplinary Nursing Notes", document: 1) 11/6/2016 2:30 p.m., New Order received X-ray right knee-pain/swelling; 2) 11/6/2016 4:45 p.m., notified of X-ray results, new order received to send resident to [local hospital] for evaluation; 3) 11/6/2016 5:35 p.m., Resident transported to [local hospital]; and 4) 11/7/2016 [no time written] Late Entry 11/3/2016. Nurse was notified by CNA [certified nursing assistant] that she [R1] slid out of bed and lowered to floor and noted no injury...facial expressions without and abnormal per CNA...

On 11/9/2016, at 2:20 p.m., E5 (Certified Nursing Assistant) stated, " On 11/3/2016, I stepped out of [R1's] room to get an incontinence pad and when I came back in the room, [R1] was on the floor. R1's bed was elevated waist high, and E4 (Certified Nursing Assistant)] was standing on the opposite side of the bed. [E4] told me [R1] slid out of bed...[R1] screamed when we put her back in to bed."

On 11/10/2016, at 10:12 a.m., E4 confirmed: R1's bed was waist high; while E5 stepped out of the room E4 turned R1, in the bed, the opposite direction E4 was standing; R1 "wiggled" and fell off the bed; and facility policy states when turning a resident, you turn them towards your body so they will not roll off the bed.

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F 323	Continued From page 5 Local hospital, "ED {Emergency Department] Provider Notes", dated 11/6/2016, at 6:39 p.m., written by Z1 (Emergency Department Medical Doctor) document: "She [R1] has severe dementia and will not voice pain, but she screams if the right leg is touched or manipulated; Diagnosis-Closed displaced comminuted fracture of shaft of right femur." R1 admitted to the local hospital for medical management. Local hospital "Discharge Summary", dated 11/9/2016, at 1:19 p.m., by Z2 (Medical Doctor), document; "...found to have multiple comminuted, impacted, and displaced fractures of the distal right femoral metaphysis, as well as likely patellar fracture. Orthopedic surgery was consulted and advised against operative management. Right lower extremity was unable to be immobilized secondary to lower extremity contracture. Orthopedics recommended hospice care and palliative care was consulted. Discharged with hospice."	F 323		