STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013437	A. BUILDING: _____ B. WING _____	C 02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND SENIOR LIVING	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) COMPLETE DATE
S 000	Initial Comments Investigation of Facility Reported Incident of 1/27/22/IL143600	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 These regulations were not met as evidenced by: Based on record review and interview the facility failed to ensure R1's emergency nurse call device was accessible and within reach for R1, as specified in R1's plan of care, to obtain assistance and to prevent falls. R1 attempted to self transfer and ambulate and sustained a fall resulting in a head injury (laceration with staples) requiring emergency medical treatment. R1 is one of three residents reviewed for falls in the sample of three. Findings include: The facility Policy and Procedure: Call Light System, dated 10/1/19, documents the following: "Policy: It is the policy of this facility to provide a means of communication to meet the needs of each resident. Procedure: Assure the call light is within easy reach of the resident." R1's undated face sheet documents diagnoses of Acute Scalp Laceration and History of Unsteady of Feet, Muscle Weakness, History of Falling, Abnormal Posture, and Difficulty in Walking. R1's Minimum Data Set (MDS) dated 12/24/21 documents R1 as having modified independence for cognitive decision making. This same MDS documents R1 as requiring extensive assistance of one person for bed mobility, transfers, locomotion on unit, dressing, toileting and personal hygiene. R1's Fall Risk Assessment dated 12/23/21 documents R1 as high risk for falls. R1's Care Plan intervention revised 3/21/21	S9999		

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S9999	Continued From page 2	S9999		

documents R1 requires 1-2 assist for transfers. This same Care Plan documents an intervention dated 8/24/20 to 'be sure call light is within reach and encourage (R1) to use call light for assistance. Needs prompt response for all requests for assistance.'

R1's Hospital Discharge Note dated 1/27/22 documents diagnosis of 'Fall and Scalp Laceration'.

R1's Fall Investigation Report dated 1/27/22 documents "(R1) was unable to find call light, (R1) got up, pushed overbed table in room and caught on recliner and (R1) fell down."

R1's Nurse Progress Noted dated 1/27/22 at 6:06 AM documents "(V10) observed (R1) lying on right side in front of recliner at 6:06 AM. A puddle of blood noted under (R1) head. (R1) complained of throbbing head pain. Call light was wedged between the bed and hand rail (enabler rail). (R1) stated 'I (R1) did not know where (R1) was going, but (R1) was pushing bedside table across the room. (R1) stated tried to find (R1) call button."

R1's Post Fall Evaluation dated 1/27/22 documented R1 as having a scalp laceration and R1 complained of "throbbing pain" as a result of fall.

On 2/15/22 at 1:15 PM R1 stated "My (R1) head hurt then. It's ok now. It hurt so bad. Of course it hurt. (R1) was trying to use the bathroom. (R1) pushed the table (bedside table) to walk with. (R1) am supposed to use a walker. (R1) couldn't find the walker. (R1) couldn't find the bell (call light) either."

On 2/15/22 at 1:35 PM V9 Restorative

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S9999	Continued From page 3 Nurse/Licensed Practical Nurse (LPN) stated "(R1) fell on 1/27/22 and obtained six staples to the back of (R1) head. The staff attached (R1)'s call light to the assist rail too low. (R1) tried to find the call light to ask for help but could not find it due it being attached too low. (R1) does not have the mobility to be able to reach (R1) call light when it was that low." On 2/16/22 at 10:45 AM V12 Physician stated "(V12) was made aware of (R1) fall on 1/27/22. (R1)'s posterior head injury could lead to a small concussion, a headache for four to six weeks and localized pain. This fall could have possibly been prevented had the staff made the call light accessible to (R1)." On 2/16/22 at 11:00 AM V2 Director of Nurses (DON) stated "(R1) fell on 1/27/22. The root cause of (R1) fall was that (R1)'s call light was not accessible. (V2) was told that (R1) call light was wedged between (R1) enabler bar and mattress too low for (R1) to reach. Our (facility) staff have been educated on the importance of always making sure the call light is accessible to the resident. The call light is super important to (R1) because (R1) uses it to gain the attention of staff when (R1) needs something. (V2) can not say this fall would have been prevented if (R1) had the call light accessible but there may have been a better outcome." " B "	S9999		