Illinois Department of Public Health

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 03/30/2022

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 Facility Reported Incident of 3/10/22/IL145211	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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	S9999		

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to implement a post fall	S9999		

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intervention for one of three residents (R1) reviewed for falls in the sample list of three. This failure resulted in R1 falling from R1's wheelchair and obtaining a Nondisplaced Distal Radius Fracture and a cast being placed on R1's left forearm and wrist.

Findings include:

The facility's Falls and Fall Risk Managing policy with a revised date of August, 2008 documents, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling." "The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls." "Staff will identify and implement relevant interventions (e.g. {for example}, hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling."

R1's Serious Injury Incident Report documents on 3/10/22 at 4:15 PM, R1 had a fall with serious harm or injury. The "Detailed Incident Summary" completed by V2 (Director of Nursing) documents, "Nurse (V8 Registered Nurse) was notified that R1 was on floor. Upon entry into room R1 was noted to be lying on R1's left side on R1's left hand with wheelchair next to R1, call light within reach on R1's recliner. R1 was toileted 15 minutes prior on the commode and was placed back in wheelchair, bedside table beside R1 with call light on recliner within reach and reacher on the (bedside) table. Call light was not noted to be turned on when R1 sustained fall. R1 was alert and oriented x (times) 3 following the fall. R1 is fully aware of R1's limitations and is

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S9999	Continued From page 3 capable of utilizing the call light. R1 noted to have a raised area to left forehead and c/o (complaints of) pain in left hand but no swelling or discoloration noted at time of fall. MD (Medical Doctor) notified with new order for R1 to transport to ED (Emergency Department) for further evaluation and treatment. Investigation completed. Root cause noted to be that R1 was reaching for an item on the floor and slipped out of wheelchair. R1 returned to facility via POV (private vehicle) with HCPOA (Health Care Power of Attorney) with a splint in place to the left wrist/forearm and a sling due to a Left Radial Fracture. Pain management in place. (Non-slip material) placed in R1's wheelchair. This incident has been reviewed by the IDT (Interdisciplinary Team) and R1's care plan has been updated accordingly. HCPOA made aware and is agreeable to intervention in place." R1's Order Summary Report dated 3/30/22 documents diagnoses including Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Abnormal Posture and History of Falling. R1's Minimum Data Set (MDS) dated 1/7/22 documents R1 was totally dependent on two plus persons for transfers and did not ambulate. This MDS documents R1 was not steady, only able to stabilize with staff assistance during transitions from a seated to standing position and had impairment of one side of R1's upper and lower extremities. R1's Care Plan dated 1/19/22 documents R1 is at risk for falls. This Care Plan documents an intervention of anti roll back brakes in place dated 2/9/22 after a fall on 2/9/22. R1's Fall report dated 2/9/22 documents an Intervention by V10 (Restorative Nurse), to have anti roll backs placed on R1's wheelchair.	S9999		

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R1's Post Fall Evaluation dated 3/10/22 at 4:15 PM by V8 (Registered Nurse/RN) documents under "Contributing Factors" that the wheelchair was involved and the wheelchair brakes were unlocked.

R1's Nurse's Note dated 3/10/22 at 4:58 PM by V8 RN documents R1 sustained a fall and complained of left hand pain and had a goose egg on R1's left forehead and neuro (neurological) checks were initiated. R1's Nurse's Note at 5:00 PM documents no swelling or discoloration of the left hand.

R1's Nurse's Note dated 3/10/22 at 8:00 PM by V12 (Licensed Practical Nurse /LPN) documents V12 noticed swelling and bruising of the left wrist that had not been there before. This note documents V12 notified V13 Physician and obtained orders for xrays of the left wrist. R1's Nurse's Note dated 3/11/22 at 12:30 PM by V2 (Director of Nursing) documents the radiology company had not arrived to perform the xray of R1's wrist and V2 contacted R1's POA (Power of Attorney). R1's family wanted to take R1 to the emergency room at that time for the xray so R1's POA picked up R1 at the facility and took R1 to the emergency room.

R1's Diagnostic Radiology report dated 3/11/22 documents the "Reason for the Exam" as fall, pain. R1's Diagnostic Radiology report dated 3/11/22 at 2:49 PM, documents Diffuse Osteopenia. Nondisplaced oblique distal radius fracture. R1's Emergency Room Discharge Instructions dated 3/11/22 documents "Your diagnosis Fall, Closed Head Injury, Distal Radius Fracture, Shoulder Injury" and to keep R1's left wrist in a splint in an arm sling and to follow up

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S9999	Continued From page 5 with the Orthopedic Physician in 2-3 days. R1's Orthopedic Physician note by V14 (Physician) dated 3/15/22 documents R1 was placed in a short arm cast and has to follow up in three weeks. On 3/29/22 at 1:52 PM, R1's wheelchair did not have any anti roll back brakes on it. At this time V5 (Maintenance Director) confirmed R1's chair did not have anti roll back brakes on R1's wheelchair and V5 did not recall seeing the anti roll back brakes on R1's wheelchair. On 3/29/22 at 2:50 PM, V2 stated that V2 could not confirm anything regarding the anti roll back brakes for R1 without looking in R1's chart. At 4:15 PM V2 provided a work order that documents "place anti roll back brakes" on R1's wheel chair. This work order is dated 2/9/22 and signed as completed by V11 (Maintenance Assistant) on 2/10/22. On 3/29/22 at 4:18 PM, V11 stated that V11 placed anti roll back brakes on R1's wheelchair but has no idea what happened to them. V11 stated that V11 did not remove them and does not know who did. On 3/30/22 at 9:05 AM, V9 (Certified Nursing Assistant/CNA) stated that V9 was the one that found R1 on 3/10/22 on the floor in R1's room. V9 stated it appeared that R1 leaned forward out of R1's wheelchair and fell out. V9 stated that V9 could not remember seeing anti roll back brakes on R1's wheelchair. On 3/30/22 at 9:25 AM, V10 (Restorative Nurse) stated that after R1's fall on 2/9/22 they decided to go with anti roll back brakes on R1's	S9999		

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S9999	Continued From page 6 wheelchair because R1's appeared to be trying to raise up out of the wheelchair and the anti roll backs would prevent the wheelchair from rolling away. V10 stated that V10 has no idea why the anti roll back brakes were not on R1's wheelchair on 3/10/22 when R1 fell out of R1's wheelchair and fractured R1's wrist. V10 confirmed the anti roll backs were still not on R1's chair on 3/29/22. On 3/30/22 at 10:10 AM, V8 (RN) confirmed that V8 was the nurse that assessed R1 after the fall on 3/10/22. V8 stated that V8 does not remember there being any anti roll back brakes on R1's wheelchair at the time of the fall on 3/10/22. On 3/30/22 at 10:24 AM, V15 (R1's current Physician) stated that R1's radiology report dated 3/11/22 documents R1 has Osteopenia and V15 stated the fact that R1 has Osteopenia makes it more likely that a short fall from the wheelchair would cause a fracture. (B)	S9999		