STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145229	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE HEALTH-SPRINGFIELD	**900 NORTH RUTLEDGE SPRINGFIELD, IL 62702**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide safe transfers for 2 of 8 residents (R220, R232) reviewed for falls in the sample of 32. This failure resulted in R220 sustaining a shoulder fracture. Findings include: 1. R220's face sheet documents R220 was admitted to facility on 2/17/2020 with a [DIAGNOSES REDACTED]. R220's Care plan, dated 2/24/2020, documents: Fall Risk: (R220) has a history of falls. He is dependent on a mechanical lift for transfers, and is wheelchair bound. History of stroke 2008 with left side [MEDICAL CONDITION] 6/15/2020 Fracture to right shoulder acromion. Has had minimal complaints of pain. INTERVENTIONS: 02/24/20-Therapy to continue to work on transfers 06/19/20-mechanical lift for all transfers r/t (related to) R. (right) shoulder fracture. 3/10/2020 changed on 06/19/20 (mechanical) lift for all transfers. R220's Nurses note, dated 6/15/2020 12:00pm, Health Status Note documents: This writer received a self reported fall from patient at this time. Patient (R220) stated that he fell during transfer last night and got back to chair with mechanical lift. No injuries but c/o (complaint of) pain to right shoulder. RUE (right upper extremity) limited ROM (range of motion) per norm but he stated right shoulder is sore. MD (medical doctor) made aware, administered ([MEDICATION NAME]) and placed order for X-ray at this time. Facility's investigation report, dated 6/15/2020, documents: (R220) self reported a fall and expressed pain in the right shoulder. Physician and POA (Powere of Attorney) notified. Order received for an X-ray. DON (Director of Nursing) and Administrator have been notified. On 6/15/2020 resident reported to staff nurse that he was experiencing pain to right shoulder as a result of a fall that occurred the previous night 6/14/20. Staff and resident interviews conclude that resident's right upper extremity became unsupported during a sit to stand transfer and that staff assisted to complete transfer safely resulting in the resident being seated on the floor. R220's Nurses note, dated 6/16/2020 01:28am, Health Status Note documents: (R220) has Right acromion fracture. Lateral displacement of the distal fracture fragment is identified related to a fall on 06/14/2020. POA (power of attorney) and Dr. notified of the results. Waiting on a call back from the MD. Patient denies pain or any discomfort at this time. R220's Nurses note, dated 6/18/2020, documents: 6/14/2020 9:00 PM Health Status Note Late Entry: Note Text: CNA (Certified Nursing Assistant) notified this writer, the resident is on the floor. He did not fall, (I) the CNA lowered him to the floor. This writer talked to the resident, He confirmed, he doesn't have any pain, he was not injured anywhere. He did protest going to bed and not in his chair. On 8/12/2020 at 09:40 AM, R220 stated, I told them (staff) the higher I am up in the sling the safer I am. R220 stated, I fell and broke my shoulder. R220 is alert and oriented and answers questions appropriately. On 8/12/20 at 12:51 PM, V33, Licensed Practical Nurse (LPN), stated, When I was giving his (R220) morning medication, (R220) stated, Can I have a pain pill? My right shoulder got caught in sling and I fell all the way to the floor. V33 stated, (R220) is dead weight. V33 stated, I was surprised because (R220) is with it, he knows what is going on. V33 stated, (Night agency nurse V34), She was an agency Nurse (V34), I don't know if she knew she had to report this or if she knew what a fall was. V33 stated, I received no report that (R220) had fallen. V33 stated, I immediately notified my manager and ordered an X-ray. V33 stated, Staff was to only use a mechanical Sit to Stand if bedside commode was right next to resident's bed. V33 stated, I haven't seen that Agency Nurse (V34) since the incident. V33 stated, (R220) is the type of person that doesn't bother you. V33 stated, I asked my aide if she got any report and she stated, she did. V33 stated, The night CNA was (V35) and my CNA was (V36). On 8/12/20 at 3:02pm, V35, CNA, stated, (R220) is not stable on the sit to stand. V35 stated, (R220) is a heavy man. V35 stated, I was transferring (R220) back to bed and he stated, Hurry up, I'm going to fall. V35 stated, I had to wipe him clean. V35 stated, (R220) stated again, 'Hurry up I'm going to fall'. V35 stated, Then (R220) let go. V35 stated, I was able to catch (R220) so that he didn't slam to the ground. V35 stated, I got another CNA and the Nurse (V34). V35 stated the sit to stand is not made for (R220) that can't stand. V35 stated, Multiple times we told nurses and they don't do anything. V35 stated, I didn't report it to dayshift CNA, I reported it to my nurse (V34). V35 stated, I doubt if that agency nurse (V34) still works there. V35 stated, I had heard that (R220) has fallen in the shower before. V35 stated, (R220) had to have 2 staff with him in the shower because he was afraid of falling. V35 stated, I would probably use a mechanical lift next time. V35 stated, Physical Therapy never worked with me, to train me to use the sit to stand for (R220). On 8/12/2020 at 3:25PM, V36, CNA, stated, (R220's fall) wasn't reported. V36 stated that she asked R220, Did ya fall yesterday? V36 stated, (R220) stated something about sit to stand didn't move fast enough and he slipped out. V36 stated, A lot of the girls were intimidated with using sit to stand. On 8/17/2020 Attempts to call R220's Physician (V38) were made and no return calls received. The facility's Employee Disciplinary Action Form for V34, dated 6/16/2020, documents V34 received a Verbal Warning for Failure to document a resident incident. 2. R232's Care Plan, dated 5/12/2020, documents (R232) is at risk for falls due to forgetful, unsteady at times, incontinent of urine, tries to get up without help at times, weakness and history of fall. ADL (activities of daily living) Self Care Performance Deficit related to admit 11/28/18 after hospital stay, weakness & unsteady, some confusion and may attempt to get up without help. Unable to perform ADL's independently. Deficit: Unsteady on feet, tires easily, poor balance. Apply gait belt, have her push up from surface and grasp walker to gain balance. R232's Minimum Data Set (MDS), dated [DATE], documents Extensive assist of 1 for transfer. R232's transfer assessment, updated 3/2020, posted on closet door documents Stand and Pivot transfer with gait belt. With assistive device- Walker On 7/20/2020 at 11:40 AM, V5, Registered Nurse (RN), assisted R232 from the toilet to her recliner. V5 grabbed R232's left arm and assisted her to a standing position from the toilet. V5 pulled up R232 pants. R232 began wavering her body back and forth grabbing the wall and walker. V5 grabbed R232's arm and assisted her to the recliner. V5 did not apply gait belt prior to transfer and ambulation. The Facility's Fall Assessment and Management Policy and Procedure, dated 4/2019, documents, It is the policy of this facility to assess each resident's fall risk on admission, quarterly, and with each fall. This will help facilitate an interdisciplinary approach for care planning to appropriately monitor, assess and ultimately reduce injury risk. Factors related to the risk will be addressed and care planned.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A. Based on observation, interview, and record review, the facility failed to perform proper hand hygiene and properly handle meal trays/containers to prevent the spread of infections for 7 of 10 residents (R212, R213, R214, R222, R223, R224, R232) reviewed for infection control in the sample of 32. Findings include: 1. On 7/20/20 at 12:20 PM, V5, Registered Nurse (RN), performed a finger stick blood sugar to R222. V5 did not perform hand hygiene prior and did not wear gloves. V5 administered 10 units of Humalog insulin to R222. V5 did not perform hand hygiene prior and did not wear gloves. V5 did not perform hand hygiene after administering the insulin. On 7/10/20 at 12:26 PM, V5 administered [MEDICATION NAME] 600 mg 1

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 IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145229	A. BUILDING _____ B. WING _____	**08/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE HEALTH-SPRINGFIELD	**900 NORTH RUTLEDGE SPRINGFIELD, IL 62702**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) tablet, Carbdopa [MEDICATION NAME] 25/250 1 tablet and [MEDICATION NAME] 5/325 mg 1 tablet to R222. V5 did not perform hand hygiene before or after administering the medications. 2. On 7/20/20 at 12:33 PM, V5 administered [MEDICATION NAME] 300 mg 1 tablet to R223. V5 did not perform hand hygiene before or after administering the medication. 3. On 7/20/20 at 12:36 PM, V5 administered [MEDICATION NAME] 25 mg 1 tablet and [MEDICATION NAME] 325 mg to R224. V5 did not perform hand hygiene before or after administering the medication. On 8/13/20 at 3:16 PM, V23, Infection Preventionist, stated, I would expect staff to perform hand hygiene and wear gloves prior to patient care. Also, when doing (finger stick blood sugars), giving insulin. Hand hygiene should be done between medication pass and between glove changes. The facility Policy and Procedure for Hand Hygiene, dated 1/1/2014, documents, PURPOSE: To improve hand-hygiene of health care workers and to reduce transmission of pathogenic microorganisms to patients and personnel in heath-care settings. Indications: Indications for hand hygiene and hand hygiene antisepsis include, C. Decontaminate hands before having direct contact with patients. and F. Decontaminate hands after contact with a patient's intact skin (e.g , when taking a pulse or blood pressure, and lifting a patient). G. Decontaminate hands after contact with body fluids or excretions, mucus membranes, non-intact skin, and wound dressings. 4. On 7/20/2020 at 11:40 AM, V5, RN, assisted R232 with toileting. V5 donned gloves and assisted R232 with perineal care. After cleansing R232's buttocks, V5 applied clean undergarment and dressed R232 using the same gloves. V5 did not remove and/or change gloves before applying clean undergarment and dressing resident. On 7/20/2020 at 1:56 PM, V5 assisted R232 to the toilet. V5 removed R232's moderately stool soiled depend and placed it in the trash can using his bare hands. V5 assisted R232 to sit on toilet and left the room. V5 did not apply gloves prior to assisting with toileting and did not perform hand hygiene before or after assisting R232 with toileting. 5. R212's Report of Laboratory Results, dated 7/22/2020, documents Positive [DIAGNOSES REDACTED] CoV-2. R212's Care Plan, dated 6/5/2020, documents Resident is at risk for infection, potential for contracting COVID-19. R212's Progress notes, dated 7/22/2020, documents Resident COVID positive. On 8/11/2020 at 12:23 PM, V32, Certified Nursing Assistant (CNA), removed a disposable food container, from a cart and placed it on the floor outside of R212's room. V32 removed his gown and gloves, picked up the disposable container from the floor and entered R212's room. V32 verified the disposable container was served to R212. 6. R214's Report of Laboratory Results, dated 7/22/2020, documents Positive [DIAGNOSES REDACTED] CoV-2. R214 Progress notes, dated 7/22/2020, documents Positive COVID Notification: Writer called Resident's emergency contact to inform her of Resident's positive COVID test. On 8/11/2020 at 12:24 PM, V31, Licensed Practical Nurse (LPN), removed a disposable food container and cup of fluid from a cart and placed both on the floor outside of R214's room. V31 changed her personal protective equipment (PPE), donned a new gown, and pair of gloves. V31 picked up the container and the cup, dropping the cup back onto the floor. V31 picked up the cup and entered R214's room. V32 verified the disposable container and cup were served to the R214. 7. R213's Report of Laboratory Results, dated 7/22/2020, documents Positive [DIAGNOSES REDACTED] CoV-2. R213's progress notes, dated 7/22/2020, documents Positive COVID Notification: Writer called Resident's emergency contact to let him know his mother's test came back positive On 8/11/2020 at 12:28 PM, V31 removed a disposable food container from the cart and entered R213's room. V31 placed the disposable food container on top of a red barrel, located in R213's room, labeled biohazard. V31 then donned gown and gloves, removed food container from the red barrel, and placed the food container on R213's bedside table. On 8/11/2020 at 12:30 PM, when asked about the delivery of the food containers, V31, stated, I guess they expect us to take the cart from room to room. It's kind of hard when you only have 2 people. On 8/12/2020 at 12:20 PM, V30, Infection Control Preventionist, stated Each resident has a biohazard container in their room. This is used to put dirty and contaminated items in. The nursing staff are to pass the trays. This can be a 1 person task. Expect staff to utilize proper infection control practices. I do not expect the staff to place the food containers on the floor or on the biohazard container before serving to the resident. On 8/13/2020 at 4:09 PM, V2, Director of Nursing, stated, I would expect the staff to perform good infection control practices. Placing food trays on the floor and on the biohazard container is not good infection control practices. I would expect the staff to remove the food from the cart and take it in the room placing it on the bedside table. The Facility's Infection Control Policy and Procedure, dated 3/1/2010, documents It is the policy of this facility to utilize standard precautions facility wide.