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
	IL6003800	A. BUILDING: _____ B. WING _____	C 02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF CHAMPAIGN	1915 SOUTH MATTIS STREET CHAMPAIGN, IL 61821

(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
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)4)6 300.3240a) 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. 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: 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/11/16

Illinois Department of Public Health

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S9999	Continued From page 1	S9999		

agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on interview, and record review, the facility failed to ensure residents remain free from physical abuse. This applies to two of four residents (R1, R2) reviewed for abuse. R2 sustained a facial laceration as a result of this incident.

The findings include:

R1's Nurse's Note dated 2/7/16 at 10:00 PM, R1 stated R1 and a Certified Nursing Assistant (CNA, E5) got into an argument and the CNA (E5) threw a drink at R1. R2's Nurse's Notes dated 2/7/16 at 5:15 PM, R2 stated a staff member (E5) kicked her in the knees. Later while in the dining room, the same staff member threw a glass at R1, which hit R2 on the left cheekbone, causing a one half inch laceration. Steri-strips were applied.

On 2/18/16 at 1:00 PM, R2 was in her bedroom seated in her wheelchair. There was a purplish bruise to R2's left cheekbone. R2 stated two people got into an argument in the dining room and R2 was hit with a glass, causing the bruise to her left eye/cheek area.

On 2/19/16 at 1:00 PM, R1 stated R2 told R1 she had been mistreated by E5. When R1 asked E5 why she had mistreated R2, E5 poured water on R1 then threw a glass at R1, which then hit R2 instead.

The facility's Final Investigation, dated 2/10/16,

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S9999	Continued From page 2 states on 2/7/16 R1 and R2 were seated at the dining room. R1 and E5 (CNA) were having a verbal argument. R1 threw water on E5, then E5 poured water on R1 and threw a glass at R1, which accidently hit R2 on the left cheekbone by her eye. During interview (with R2) it was alleged that E5 also pushed R2's wheelchair with her foot to move her out of the room. After investigating the incident, E5 was terminated from her employment at the facility. On 2/19/16 at 10:30 AM, E1 (Administrator) stated upon investigation of the incident occurring on 2/7/16 between E5, R1, and R2, the abuse was substantiated and E5's employment was terminated. (B)	S9999		