

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004493	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2017
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NAME OF PROVIDER OR SUPPLIER HELIA HEALTHCARE OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST HILLVIEW AVENUE GREENVILLE, IL 62246
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S 000	Initial Comments Annual Health Statement of Licensure Violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 300.3240a) 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. Restorative measures	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

06/09/17

Illinois Department of Public Health

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

HELIA HEALTHCARE OF GREENVILLE

400 EAST HILLVIEW AVENUE
GREENVILLE, IL 62246

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shall include, at a minimum, the following procedures:
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

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident

These requirements were not met as evidenced by:

Based on record review and interview the facility

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S9999	<p>Continued From page 2</p> <p>failed to implement fall interventions for five of six residents (R2, R3, R5, R6, R8) reviewed for falls in the sample of 15. This failure resulted in R5's fall with laceration requiring sutures.</p> <p>Findings Include:</p> <p>1. On 05/16/17 at 9:35 AM, R5 was in a wheelchair at the Nurse's Station. No staff was present at the Nurse's Station. At 3:30 PM, R5 was in the wheelchair at the front door of the facility out of view of staff. On 05/17/17 at 9:30 AM, R5 was in the wheelchair sitting in front of the exit door in the dining room not in staff view. At 10:30 AM, R5 was in the same place in front of the exit door sleeping in the wheelchair. On 05/18/17 at 9:30 AM, R5 was propelling down the B hallway (R5's room is on A hall) not in view of staff. At 10:10 AM, R5 was at the front entrance in the wheelchair not in view of staff. On 05/19/17 at 9:20 AM, R5 was sitting in the wheelchair at the front entrance of the facility sleeping, not in view of staff.</p> <p>The Physician Order Sheet (POS), dated 05/01/17, documented R5 had the following diagnoses, in part as, Alzheimer's Disease, history of falling and Dementia.</p> <p>The Minimum Data Set (MDS), dated 04/23/17, documented R5 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4 and required total assist of at least two staff for transfers, dressing, bathing and toileting. It also documented R5 required extensive assist of at least two staff for bed mobility and was always incontinent of both bowel and bladder.</p> <p>The Care Plan, dated 05/13/17, documented R5</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>was identified as requiring extensive assistance with all activities of daily living (ADL's) and was a high risk for falls. The falls interventions listed, in part as, observe or monitor resident frequently and closely, place in supervised area when out of bed and check resident every now and then.</p> <p>The Incident/Occurrence Report, dated 05/22/16 at 3:15 AM, documented R5 was found on the floor in his room with his roommates wheeled walker turned over and the alarm being in the off position. It documented R5 suffered an abrasion to the left outer elbow, an abrasion to the right outer knee and bilateral knees reddened and bruised. There were no new or progressive interventions implemented or additions made to the Care Plan.</p> <p>The Incident/Occurrence Report, dated 06/04/16 at 2:25 AM, documented R5 was found on the floor in his room with the alarm not sounding and on the floor next to the bed. It documented R5 had slipped in his own urine and fell hitting his head causing a hematoma and a small laceration to his coccyx. There were no new or progressive interventions implemented or additions made to the Care Plan.</p> <p>The Incident/Occurrence Report, dated 06/04/16 at 8:30 PM, documented R5 was found on the floor next to his wheelchair in the dining room with no documentation of alarm sounding. It documented R5 suffered a small skin tear on the left little finger. There were no new or progressive interventions implemented or additions made to the Care Plan.</p> <p>The Incident/Occurrence Report, dated 07/07/16 at 6:45 AM, documented R5 was found on the floor in the dining room with the alarm not</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>tour of A hall, E2 stated R5 has had a personal alarm on his wheelchair since admitted to the facility due to wandering behaviors and poor cognitive ability.</p> <p>The Incident/Occurrence Report, dated 03/10/17 at 9:00 PM, documented R5 was found on the floor by his wheelchair in the dining room, alarm functioning not documented. It documented R5 had suffered laceration to the left temple measuring 2 cm. There were no new or progressive interventions implemented or additions made to the Care Plan.</p> <p>The Incident/Occurrence Report, dated 03/11/17 at 6:05 PM, documented R5 was found on the floor by his wheelchair with the alarm sounding in the hallway. It documented R5 suffered an abrasion to the left hand measuring 1.0 cm x 0.5 cm. There were no new or progressive interventions implemented or additions made to the Care Plan.</p> <p>The Incident/Occurrence Report, dated 04/01/17 at 6:50 AM, documented R5 was found in the dining room by his wheelchair with the alarm sounding. It documented R5 suffered a red area above the left eye. There were no new or progressive interventions implemented or additions made to the Care Plan.</p> <p>The Incident/Occurrence Report, dated 04/01/17 at 4:15 PM, documented R5 was found on the floor by his wheelchair with the alarm sounding by kitchen staff in the adjacent room. It documented R5 had hit his head on the floor, however no injury noted. There were no new or progressive interventions implemented or additions made to the Care Plan.</p>	S9999		

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The Incident/Occurrence Report, dated 04/17/17 at 10:45 AM, documented R5 was found on the floor in front of his wheelchair, alarm functioning not documented. It documented R5 suffered two skin tears to the forehead, one measuring 0.1 cm x 1.5 cm and the other 3.0 cm x 0.1 cm. There were no new or progressive interventions implemented or additions made to the Care Plan. A second fall was documented on 04/17/17 at 4:10 PM where R5 was found on the floor by his wheelchair, alarm functioning not documented. There were no documented injuries or interventions implemented.

The Incident/Occurrence Reports documented R5 had fallen from his wheelchair or bed from the dates of 05/18/16 to 05/14/17 a total of 45 times with a range of injuries from skin tears, bruises, redness, tooth loss, hematoma's and lacerations. There were only repeated interventions documented, such as, monitoring and keeping R5 in populated areas. There were no documented progressive interventions.

On 05/16/17 at 9:30 AM, E2 stated R5 falls often and has alarms on his wheelchair and often transfers himself. On 05/17/17 at 11:00 AM, E2 stated they (facility) have tried everything from different alarms, therapy, snacks and toileting for R5. E2 stated R5 never complains or talks much. E2 stated she's not sure what to do to keep R5 from falling. E2 stated they have discussed a lap top cushion or lap restraint in the past, but she feels he could get out of them, saying "he's very fidgety."

On 05/17/17 at 10:30 AM, E8, Registered Nurse (RN), stated R5 doesn't know not to get up without assist. E8 stated R5 cannot use a call light. E8 stated she wasn't sure what to do to

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S9999	<p>Continued From page 7</p> <p>keep R5 from falling except "keep an eye on him." At the time of this interview, R5 was observed with E8 present in the dining room in front of the exit door in his wheelchair sleeping. Staff would have to walk about half way into the dining room from the Nurses Station and halls to visually see R5.</p> <p>On 05/17/17 at 10:35 AM, E14, Certified Nursing Assistant (CNA), stated R5 cannot use a call light or verbalize his needs. E14 stated R5 does fall a lot, but does not know what would help to keep him from getting up all the time.</p> <p>On 05/18/17 at 12:55 PM, Z3, Medical Doctor, stated R5 had the cognitive abilities of a two year old, and, like a child, was a very tactile person where he likes to touch and feel things. Z3 stated this is why R5 was falling so much because he attempts to get up or bends over in the wheelchair to investigate, and falls. Z3 stated she was not sure how to keep him from doing this because his level of cognition decreases his ability to be re-directed. Z3 further stated that the facility cannot restrain R5 because "the State" won't allow it. After careful explanation of the regulations, Z3 stated R5's safety comes first and would be open to discussion for clearly stated reasons or scenario's where a restraint would be more beneficial for R5's safety and allow him to still have the freedom to propel around the facility.</p> <p>2. On 05/16/17 at 11:45 AM, R8 was ambulating with a wheeled walker down the A hallway. R8 was ambulating with the wheeled walker way out in front of him in a reaching-like manner. R8 ambulated with an unsteady gait. On 05/17/17 at 2:30 PM, R8 was ambulating in the same manner back to his room.</p>	S9999		

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S9999	<p>Continued From page 8</p> <p>The POS, dated 05/01/17, documented R8's diagnoses, in part as, Unspecified Mental Disorder, Intracranial Injury, history of falls, Alzheimer's Disease, Schizoaffective Disorder and Bipolar Disorder.</p> <p>The MDS, dated 04/03/17, documented R8 was severely cognitively impaired with a BIMS score of 3. It documented R8 required limited assist of one staff for toileting, hygiene and bathing, and was frequently incontinent of bladder.</p> <p>The Care Plan, dated 04/11/17, documented R8 was on psychotropic medications, was cognitively impaired, needed supervision and was tracked for wandering. It also documented R8 had a history of falling related to becoming unsteady and attempting to ambulate without his assistive device. Interventions listed, in part as, verbal reminders to not ambulate without wheeled walker.</p> <p>The Incident/Occurrence Report, dated 02/12/17 at 8:55 AM, documented R8 was found on the floor in the hallway with wheeled walker. It documented R8 suffered bilateral red knees. There were no new or progressive interventions implemented.</p> <p>The Incident/Occurrence Report, dated 04/04/17 at 8:45 AM, documented R8 was found on the floor in the dining room with his wheeled walker. It documented R8 suffered a hematoma/bump to the back of his head. There were no new or progressive interventions implemented. The Incident/Occurrence Report, dated 04/04/17 at 4:10 PM, documented R8 was found on the floor in his room. There were no injuries documented and no new or progressive interventions implemented.</p>	S9999		

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S9999	<p>Continued From page 9</p> <p>The Incident/Occurrence Report, dated 04/08/17 at 5:45 PM, documented R8 was found on the floor in the hallway with his wheeled walker. It documented R8 suffered reddened areas to bilateral knees. There were no new or progressive interventions implemented.</p> <p>The Incident/Occurrence log, dated from 05/09/16 to 05/12/17, documented a total of 14 falls for R8. However, the only Incident/Occurrence Reports presented during this survey were for the dates of 02/12/17, 02/16/17, 02/26/17, 04/04/17 x 2, 04/08/17, 04/10/17 and 05/09/17. The other 6 reports were not presented by the facility even after multiple attempts to review. There were no new or progressive interventions implemented.</p> <p>On 05/16/17 at 9:25 AM, E2 stated R8 had an organic brain syndrome and because of this syndrome he ambulated with his wheeled walker positioned way out in front of him. However, E2 stated if staff remind him to pull the walker closer to him when ambulating, he will. E2 stated that R8 will refuse to wear a gait belt and has been encouraged to use a wheelchair for long distances. E2 stated they have talked with family about what to do about his falling, but have not come up with a solution to keep him from falling.</p> <p>3. R3's MDS, dated 03/21/17, documents R3's BIMS score of 2, which represents severe cognitive impairment. The MDS also documents R3 requires extensive assist with one staff member for transfers .</p> <p>R3's POS, dated 05/01/17, documents R3 has a diagnosis, in part, of Alzheimer's Disease.</p> <p>R3's Incident/ Occurrence Report, dated</p>	S9999		

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S9999	<p>Continued From page 10</p> <p>01/08/17, documents R3 had a fall on 01/18/17, while toileting himself, hit is head causing a hematoma. No interventions for this fall were found on this report dated 01/18/17.</p> <p>R3's Incident/Occurrence Report, dated 3/12/17, documents R3 fell while transferring self to the toilet. No interventions for this fall were found on this report.</p> <p>R3's Incident/ Occurrence, dated 05/12/17, documents R3 was found on the floor beside his bed. No interventions for this fall were found on this form.</p> <p>R3's Care Plan, dated 01/18/17, documents R3 had a fall to the floor, and hit his head, on the floor causing a hematoma on 01/18/17. R3's Care Plan did not document any interventions for this fall. R3's Care Plan documents R3 had a fall trying to toilet himself on 03/27/17. The intervention for this fall documents remind R3 to use his call light to call for assistance. R3's fall on 05/12/17 was not documented on the Care Plan.</p> <p>In an interview on 05/18/17 at 2:00 PM, E2 stated, "We don't have any interventions for those falls."</p> <p>4. R6's BIMS, dated 4/16/2017, documents a score of 10, which represents moderate cognitive impairment.</p> <p>R6's Incident/Occurrence Reports document falls: 11/17/2016 2:25 AM no injury, 1/12/2017 at 6:45 PM no injury, 1/13/2017 at 6:10 PM no injury, 2/28/2017 2:45 PM ROM (range of motion) within normal limits open areas, 3/10/2017 at 7:30 PM no apparent injuries, 4/22/2017 at 6:05 PM no injury noted; and a skin tear 5/9/2017 found on</p>	S9999		
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S9999	<p>Continued From page 11</p> <p>left shin approximately 3 cm long dried blood.</p> <p>On 5/18/2017 at 1:07 PM, regarding progressive interventions for R6's falls on 11/17/2016, 1/12/2017, 1/13/2017, 2/28/2017, 3/10/2017, 4/22/2017 and 5/9/2017, E2 stated, "No, there are no progressive interventions." Regarding who is supposed to complete these interventions, E2 said, "I suppose that I am."</p> <p>The Falls Management Policy dated December 2016 document in part, Policy "It is the policy of the Facility to assess and manage resident falls through prevention, investigation, and implementation and evaluation of interventions. Definition: The definition of a fall refers to unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise when a resident is observed on the floor, a fall is considered to have occurred. E. Document the fall in the resident's medical record and on the 24 hour Report.</p> <p>B. Based on observation, interview and record review the Facility failed to ensure residents were not in harm's way during the transportation of a leaking oxygen tank for 5 residents in the supplemental sample (R16, R17, R18, R19 and R20).</p> <p>Findings include:</p> <p>On 05/16/2017 at 12:45 PM, during the lunch service, smoke/vapors were seen coming from</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004493	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2017
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NAME OF PROVIDER OR SUPPLIER HELIA HEALTHCARE OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST HILLVIEW AVENUE GREENVILLE, IL 62246
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S9999	<p>Continued From page 12</p> <p>behind the Nurses Station from a large metal cylinder being pushed from the Oxygen room into the hallway by E8, RN. The cylinder had a sticker on it documenting "Size: Lib 45, Content: 112 Pounds, Full Weight: 167 pounds." Vapors were coming out of the cylinder filling the hallway and making a loud cracking sound. Pieces of ice flew into the air and hit the floor. E8 then ran into the dining room area while pushing the large cylinder with vapors escaping. E8 attempted to open the side door in the main dining room while the cylinder spit out small pieces of ice. R16, R17, R18, R19 and R20 were all sitting on the outside of the tables while the cylinder was pushed near them within approximately 5 inches from the table. Pieces of ice were flying from the cylinder and the tank was eventually moved out of the exit door and to the outside.</p> <p>On 05/17/2017 at 11:00 AM, E8 stated, "I didn't know what to do when the oxygen was escaping from the tank. I just thought I was supposed to get the tank out of the building."</p> <p>On 05/17/2017 at 9:54 AM, E2 stated "If the oxygen discharges, staff can pull it out of the building if they want."</p> <p>On 05/17/2017 at 9:55 AM, E11, RN, stated, "If the oxygen was smoking, I would put a towel on it if smoke is coming out. Not sure what else."</p> <p>On 05/17/2017 at 9:48 AM, E10, Licensed Practical Nurses (LPN), stated, "I am not really sure what I am supposed to do."</p> <p>On 05/17/17 at 9:33 AM, Z2, Regional Vice President of the Manufacture of Oxygen, stated "The oxygen should in a self contained room. If while filling the oxygen it starts to leak, do not</p>	S9999		

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S9999	<p>Continued From page 13</p> <p>remove the oxygen from that room. If a towel is available, throw a towel over the leaking tank and shut the door. The material is not hazardous for breathing as it is nontoxic and just oxygen. The liquid oxygen is at a low temperature and if it makes contact with skin, it causes frostbite and burns the skin. Dragging the cylinder down the hallway could harm anyone in the vicinity of the oxygen leaking. Staff should wipe the connections to make sure there is no moisture. "</p> <p>On 05/18/2017 at 1:31 PM, E9, Maintenance Director, stated, "I heard the portable oxygen got stuck and the cylinder vented, and they needed to get it out the building and couldn't get it out of the building because the door was stuck. Staff is supposed to wipe the valves every time after they fill it. Someone probably didn't wipe it down and it got stuck."</p> <p>On 05/17/2017 at 1:30 PM, inside the Oxygen Room a Sheet on the wall documents, "Careful not to touch the bottom of Portable tank, or top of stationary, it will burn your skin." Neither document posted on the wall addresses spillage of oxygen.</p> <p>The undated Oxygen Safety Data Sheet provided by the Facility on 05/16/2017 documents in part, "Section 4: First Aid Measures: Eye contact: Contact with rapidly expanding gas may cause burns or frostbite. Skin contact with rapidly expanding gas may cause burns or frostbite." It also documents, "Section 6: Accidental release measures: Small Spill: Immediately contact emergency personnel. Stop leak if without risk, Use spark-proof tools and explosion proof equipment."</p>	S9999		

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S9999	Continued From page 14 (B)	S9999		