

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006704	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/12/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HELIA HEALTHCARE OF BELLEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 40 NORTH 64TH STREET BELLEVILLE, IL 62223
---	---

(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 Complaint Investigation: 2143225/IL133772	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.1210b) 300.1210d)6) 300.1220b)3) 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. Restorative measures 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	S9999	Attachment A Statement of Licensure Violations	

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

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006704	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/12/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HELIAHEALTHCARE OF BELLEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 40 NORTH 64TH STREET BELLEVILLE, IL 62223
--	---

(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	<p>Continued From page 1 and assistance to prevent accidents.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to utilize safe transfer techniques during mechanical lift transfers for one of three residents (R10) reviewed for accidents in the sample of 10. This failure resulted in R10 falling during a mechanical lift transfer and sustaining a hematoma to right side of head, lacerations to right side of head and right</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006704	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/12/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HELIAHEALTHCARE OF BELLEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 40 NORTH 64TH STREET BELLEVILLE, IL 62223
--	---

(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	<p>Continued From page 2</p> <p>eye, bruising to the right side of head, eye and shin, abrasion to the right knee, and skin tear to the left elbow.</p> <p>Finding includes:</p> <p>R10' Face Sheet, not dated, documents R10 has diagnoses of transient ischemic attack, muscle weakness, Primary osteoarthritis, scoliosis and anterior dislocation of right humerus</p> <p>R10's Care Plan, dated 2/4/21, documents R10 is at risk for falls. The Care Plan intervention does not address R10's use of mechanical lift or how many staff persons are needed for transfer. The Care Plan documents "Provide resident with safety device/appliance."</p> <p>R10's Minimum Data Set, dated 5/4/21 documented R10 is cognitively intact.</p> <p>R10's Nurses notes, dated 05/10/2021 04:25 PM, documents "Staff member was in resident room assisting resident with care, this writer heard a loud sound, this writer approached resident room and observed staff member in resident room alone and observed resident on floor in prone position. This writer asked staff member what happen, staff member stated that resident slid out of (full body mechanical lift) lift pad, this writer observed (full body mechanical lift) lift pad hooked on (full body mechanical lift) lift with the (full body mechanical lift) lift hooks not on correctly. This writer observed blood coming from resident head, this writer told staff member to go get more assistance to help with resident, more staff members approached room and assisted with resident to turn her on her in a supine position, resident then as observed with skin tear to left elbow and right shin, and</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006704	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/12/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HELIA HEALTHCARE OF BELLEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 40 NORTH 64TH STREET BELLEVILLE, IL 62223
---	---

(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	<p>Continued From page 3</p> <p>laceration to right side of forehead, resident never lost consciousness, resident did moan of generalized pain, ROM (range of motion) was performed WNL (within normal limits), other staff members was in resident room and applied pressure and cold pack to right side of head to the laceration, this writer called (Local Ambulance Service) related to resident injury, at this time, wound nurse was notified of skin tears and laceration, DON (Director of Nurses) was notified of resident condition."</p> <p>R10's Nurse's Notes, dated 05/10/2021 04:30 PM, documents "Resident neuro checks initiated, both eyes were slow to react at this time, vital signs 129/74 (blood pressure) 90 (pulse) 18 (respirations) 98.1 (temperature)."</p> <p>R10's Nurse's Notes, dated 05/10/2021 04:45 PM, documents "Placed call to (V12) NP (Nurse Practitioner) related to resident fall and injury, resident has orders to send to (local) ER (emergency room) to eval and treat related to resident condition."</p> <p>R10's Patient Visit Information from the local hospital, dated 5/10/2021, documents laceration of the head and pleural effusion.</p> <p>R10's Nurse's Notes, dated 05/11/2021 at 01:45 AM, documents "Recorded as Late Entry on 05/11/2021 03:18 AM Res (Resident) returned to facility. Large amount of blood soaked linens on stretcher. Neuro check performed BP (Blood Pressure) low at 82/56. Was informed by EMTs (Emergency Medical Technician) that res received Benadryl while at the hospital. Voice message left to Gen Medicine on call, (V12) NP (Nurse Practitioner) called back and updated on res, order for STAT (emergency) CBC (Complete</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006704	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/12/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HELIA HEALTHCARE OF BELLEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 40 NORTH 64TH STREET BELLEVILLE, IL 62223
---	---

(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	<p>Continued From page 4</p> <p>Blood Count). Called and placed order to (contracted) lab, req (requisition) filled out and stapled to face sheet. Rest of neuro check WNL (within normal limits). Res A&O (alert and oriented) x 3-4. Head lac (laceration) to the rt (right) side of her head 5.2 cm (centimeters) long. Wound still weeping scant blood. Appears to be 3 sutures lac but unable to tell r/t (related to) weeping and where lac is in hair. Second lac to rt side of head closer to the side of rt eye 2 cm in length with 3 sutures in place. Bruising to rt eye/head. 1x1 cm abrasion to rt shin raised and bruised. 3 cm x 2cm skin tear to lt (left) elbow. Redressed resident's wounds. Asked res if she wanted to get cleaned up r/t the amount of blood in her hair/ on her body. Stated she would like to rest for now. Res did allow this nurse and CNA to take her ponytail down and comb through hair to remove clotted blood. Will continue to monitor, call light in reach."</p> <p>On 5/12/2021 at 11:00 AM R10 sitting in her wheelchair in her room. R10 had hair in a ponytail. R10's hair was dark red in color with dried blood clots in her hair. R10 had a large hematoma to right side of her head with discoloration ranging from deep purple to black from top of right side of head to the right temporal area, surrounding right eye and cheek bone. R10 had 5 sutures to the laceration to her head and 3 sutures to the laceration to her right eye.</p> <p>On 5/12/2021 at 11:10 AM R10 stated that she fell out of the lift. R10 stated that there was only one CNA. R10 stated that she was being transferred from her wheelchair to the bed and slid out of the sling that was in motion and fell to the floor. R10 stated that she must have passed out because she didn't remember much after that.</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006704	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/12/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HELIA HEALTHCARE OF BELLEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 40 NORTH 64TH STREET BELLEVILLE, IL 62223
---	---

(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	<p>Continued From page 5</p> <p>On 5/12/2021 at 1:30 PM V6, Licensed Practical Nurse, stated that she was passing pills in the hall. V6 stated that she had 2 CNA's working with her. V6 stated that she heard a sound and went to find out what was going on. V6 stated that she entered R10's room and observed R10 on the floor bleeding from her head. V6 stated that R10 was taking a blood thinner and there was a lot of blood. V6 stated that V11, CNA, was the only staff member in the room. V6 stated that the lift sling was attached incorrectly to the lift causing R10 to slide out of the lift onto the floor. V6 stated that it is the facility's policy to use 2 staff members when using the mechanical lift. V6 stated that she expects the staff to use 2 people when transferring residents in the mechanical lift.</p> <p>On 5/12/2021 at 2:00 PM V3, Assistant Administrator, stated that R10 fell out of the full body mechanical lift because the staff attached the sling to the lift incorrectly. V3 stated that the staff was re-educated and disciplined.</p> <p>On 5/12/2021 at 3:00 PM V2, Director of Nursing, stated that V11 had been in serviced prior to R10's fall on how to use the mechanical lift and to use 2 staff members with the transfer. V2 stated this would be her expectation as well.</p> <p>On 5/12/2021 at 4:28 PM V12, Nurse Practitioner, stated that she saw and examined R10 today. V12 stated that R10 had significant head injuries as the result of her fall.</p> <p>The Facility's Falls Management Policy, not dated, documents in part "Policy: It is the policy of (Facility) Healthcare to assess and manage resident falls through prevention, investigation, and implementation and evaluation of</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6006704	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/12/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HELIA HEALTHCARE OF BELLEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 40 NORTH 64TH STREET BELLEVILLE, IL 62223
---	---

(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	<p>Continued From page 6</p> <p>interventions."</p> <p>The (Full Body Mechanical Lift) Patient Lift User Manual, not dated, documents in part in dark bold black ink "SAFETY PRECAUTIONS IMPORTANT: Before using patient lift, please read and adhere to the following safety precautions and warnings. Failure to do so could result in a serous personal injury or damage to your patient lift. "WARNING: Ensure that lifting sling loops are correctly attached to the hooks to prevent the patient from sliding out of the sling, which could result in personal injury."</p> <p>(B)</p>	S9999		