STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005870	A. BUILDING: _____ B. WING _____	C 02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF ENERGY	210 EAST COLLEGE ENERGY, IL 62933

(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: #2351186/IL156320	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210d)6) 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: 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 These requirements are not met as evidenced by: Based on interview and record review the facility	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 failed to assess for the safety of a personal rocking chair and cushion for 1 (R3) of 3 residents reviewed for an accident in a sample of 9. This failure resulted in R3 falling from the rocking chair sustaining a laceration to the forehead and a fracture of the C2 vertebra requiring local hospitalization and subsequent transfer to an out of state hospital. The findings include: R3's Face Sheet documents he admitted to this facility on 08/26/22 with diagnoses to include - diabetes mellitus II (DMII), atrial fibrillation, COPD (Chronic Obstructive Pulmonary Disease), urinary incontinence, with additional diagnosis of repeated falls dated 10/26/22. R3's admission MDS (Minimum Data Set) dated 09/18/22, section C (Cognitive Patterns) documents a BIMS (Brief Interview for Mental Status) of 14, indicating R3 was cognitively intact. Section G (Functional Status) documents R3 required extensive assistance with two or more persons for transfers. R3's balance between transitions and walking was assessed as not steady, only able to stabilize with staff assistance. R3's Care Plan documents "Problem Start Date: 08/26/2022; Category: Falls. Resident is at risk for injuries r/t (related to): Hx (history) of falls, Edited: 12/05/2022; Long Term Goal Target Date: 1/25/2022. Resident will be free of fall related injuries by next review date. Created: 9/28/2022." R3's Care Plan also documents "Approach Start Date: 08/31/2022. Approach End Date: 11/25/2022. Remind (R3) not to lean forward when sitting in wheelchair. Approach Start Date: 10/24/2022 Ensure b/l (bilateral) leg rest on w/c (wheelchair) for transporting. Created:	S9999		

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S9999	Continued From page 2 10/24/2022. Approach Start Date: 12/02/2022 Enc (encouraged) resident not to sit in rocker in room due to safety concerns of his falling. Created: 12/05/2022." R3's admission Fall Risk Assessment dated 08/26/22 documents a score of 7, indicating R3 is at moderate risk for falls. (Scoring: 0-5 Total Points = Low Fall Risk, 6-13 Total Points = Moderate Fall Risk, >13 Total Points = High Fall Risk). R3's Transfer Assessment observation details dated 08/26/22 documents "Is the resident independent in transfers and ambulation? No, Is resident able to bear weight well during transfers, do they have history of being able to bear weight? No", and "Is resident predictable, cooperative, and able to follow directions? Yes, Use gait belt with 2 assists during all transfers." R3's progress note dated 08/31/22 at 2:30 PM, documents R3 experienced an unwitnessed fall in his bathroom to include - " ... upon entering room nurse witness patient lying on left side on floor. Patients' wheelchair was in bathroom facing as if patient was coming out of bathroom. When nurse was performing head-toe assessment, nurse asked patient how he fell. Patient stated, 'he was trying to pick up a piece of garbage off floor and took a tumble.' Nurse note patient had small abrasion to left side of forehead with some dried blood coming from scratch. Nurse asked patient is he was having any other pain, and patient stated 'No'. Nurse had patient perform active range of motion to upper and lower extremities, patient could only perform to normal self, nurse noted no inward rotation or deformities to hips/legs, so nurse perform passive range of motion to make sure he was not hurting in joints ..." R3's Event Report dated 08/31/22 includes in house treatment of a 1 cm (centimeter) abrasion	S9999		

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S9999	Continued From page 3 to the forehead with a root cause for fall described as, "confusion, and weakness. Patient trying to use restroom and too weak to stand." The post fall intervention documented on R3's Event Report dated 08/31/22 was to educate resident to use call light and check on resident. R3's Transfer Assessment dated 08/31/22 includes "Is resident predictable, cooperative, and able to follow directions? No; Mechanical lift stand assist with all transfers; Use full body/mechanical lift for all transfers ..." R3's Fall Risk Assessment dated 08/31/22 documents a score of 21 points indicating R3 is a high risk for falls. R3's progress note dated 10/24/22 documents "While being taken to dining room for dinner via wheelchair, resident had his feet up. He suddenly put them down. Wearing soft soled shoes which caused him to suddenly go forward falling on the carpet. Sustained a hematoma and 2 cm laceration to right forehead. Also, a 2 cm laceration to bridge of nose. The skin on nose has carpet burn. Left hand with a 7 cm laceration to posterior hand. Steri-strips applied. A 2.5 cm laceration to left ring finger and a 1 cm laceration below that one. A 2 cm laceration to tip of left ring finger. Wedding ring removed and placed in narcotic drawer. Ice applied to right forehead and nose. Call placed to nurse practitioner who ordered x-rays of facial area and nose ...will ensure leg rest are intact when resident in wheelchair. Will continue to monitor." R3's Event Report dated 10/24/22 documents "Conclusion with root cause: Being t/p (transferred/pushed) without leg rest on bl (bilateral). Rubber soled shoes on. Had his legs up initially, but then put them down causing him to tumble forward to the carpet. Will ensure he is t/p with bl leg rest intact." R3's Fall Risk Assessment dated	S9999		

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S9999	Continued From page 4 11/29/22 documents a score of 13, indicating R3 remains at high risk for falls. R3's progress notes dated 12/02/2022 at 10:05 AM documents "guest observed on floor in room, lying on stomach with forehead on feet of bedside table, lying in puddle of blood. This nurse rolled guest off bedside table and assessed forehead, had a 4 cm by 2 cm laceration to R (right) forehead above eyebrow. Guest (R3) told this nurse the year, day of week, and who the president of the US (United States) is, he also stated, 'I was sitting in rocking chair and fell asleep that's when I was on the floor, pressure applied to forehead to stop bleeding then ice was applied. (V2 - Director of Nursing - DON) called ambulance services for transportation to hospital for eval (evaluation)." R3's Initial Incident Report dated 12/03/22 at 12:45 PM includes: " ... STATUS: On 12/2/22 Resident (R3) Dx (diagnosis) of COPD (Chronic Obstructive Pulmonary Disease), acute kidney failure, cognitive communication deficit. Was observed by Nurse in the floor of his room. Resident stated he fell asleep in his rocking chair and fell forward. Nurse assessed resident. Resident had laceration to area above right eyebrow. Resident sent to hospital for evaluation. At hospital resident received x-ray of neck. On 12-3-22 facility received notification of x-ray findings of an odontoid fracture of cervical spine C2 vertebrae ...Investigation started." R3's Final Incident Report dated 12/03/22 at 12:45 PM includes: " ...Type of Occurrence: Serious Injury ... On 12-3-22 Nurse heard resident calling from room. Nurse got to resident room and observed resident (R3) laying on floor on stomach with head against base of bedside	S9999		

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S9999	Continued From page 5	S9999		

table. Nurse immediately began to assess and tend to resident. Resident stated he was in his rocking chair, fell asleep, and had fallen forward out of rocking chair. Resident had 4 cm by 2 cm laceration to right forehead above eyebrow. Nurse applied pressure. Called ambulance. Resident sent to hospital for evaluation. All staff statements find that resident was heard calling out and was observed on floor in front of rocking chair. Resident statement tells that resident was in rocking chair prior to fall and fell asleep 'that is when I was going to the floor' per resident. Rocking chair has been removed from resident room with approval from family and resident. Spoke to family about replacing chair with recliner ...This is the final report."

On 02/15/23 at 9:42 AM, V6 (CNA - Certified Nursing Assistant) stated he remembered the incident on 12/02/22 when R3 fell and was working that day. V6 stated R3 had fallen from his rocker and the lift aid cushion was in the seat of the rocker at the time of R3's fall. V6 stated the facility did an investigation and took statements. V6's written statement dated 12/02/22 documents the following - V6 last provided care to R3 at 9:30 AM; R3 found on floor for unwitnessed fall; R3 was not usually assigned to V6; R3 was assigned to V6 at time of incident; and R3 was dry at time of incident. V6's written statement further documents "Resident (R3) was placed in his rocking chair that had a cushion from the family that resident was sitting on. Assisted with transfer. Bedside table was placed in front of resident. Resident was asked if he needed anything else, he didn't, so left the room. After leaving resident approximately 30 minutes later (activities) found resident on floor."

On 02/15/23 at 11:59 AM, V19 (Rehab

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S9999	Continued From page 6 Director/Occupational Therapist) stated she "evaluated (R3) on 08/30/22. I assessed transfers and self-care. (R3) did fine transferring with one person, he was able to get up on his own. Then, (R3) went out to the hospital and came back on 09/11/22. (R3) required 2 plus (person) assist at that time." V19 stated she recommended the "sit-to-stand" device which was safer for nursing/CNA's and R3 loved this. V19 stated progress was very slow and due to Medicare rules of non-progression and plateau he was discharged from therapy on 10/27/22. V19 verified R3 did have a wooden rocking chair from his home with a cushion. V19 said the cushion was removable and the family moved it around. V19 said the cushion was "spring loaded" as a sort of assist when standing from a sitting position. V19 stated a cushion like that would never be recommended by therapy. V19 said that the family requested a Care Plan meeting and they had one on 11/30/22. V19 said that R3 wanted to stay up in his rocker all day long, but the family was complaining about wounds, so V19 recommended R3 use a recliner, which the family was going to bring in a lift recliner. V19 said that they recommended on 11/30/22 that the family remove the rocker. V19 said it was not a safety suggestion, it was more for the elevation of the legs and compliance with that which would have been accomplished with the lift chair. V19 said the rocker was more for the family when they visited. V19 stated the "sit-to-stand" device would have been appropriate to transfer to and from his rocking chair. V19 confirmed R3's rocking chair was not assessed for safety during his stay. On 02/15/23 at 11:47 AM, V1 (Administrator) stated that two days prior to R3's fall, the facility held a Care Plan meeting on 11/30/22 that included V28 (Family Member/POA - Power of	S9999		

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S9999	Continued From page 7 Attorney). V1 said that R3 did have a wooden rocking chair with a cushion that the family brought to the facility for R3 to use. V1 said the cushion was not a normal cushion, it was a type of "lift assist" cushion to help with getting up from the rocking chair. V1 stated that V28 was told during the Care Plan meeting that they did not recommend R3 to continue using this cushion and it was not good for R3 to use the cushion in the rocking chair. V1 said that they asked the family to please take the cushion and chair home. A printed description of the "lift assist" cushion was provided by the facility and describes the cushion as a "Portable self-powered seat lifts to help you out of any chair. Easily transition from sitting to standing with the aid of this self-powered lift assist cushion. Simple hydraulic mechanisms gently lifts you as you stand." On 02/15/23 at 10:24 AM, V28 (Family Member/POA - Power of Attorney) said "The day we had planned to move him ... was the day they called and said he fell out of his rocker, and they sent him out. When I was waiting with him in the ER (Emergency Room), the doctor came in and told me his neck was broken. (Local hospital) was going to transfer him to (out of state hospital) for treatment. He was transported by ambulance." (A)	S9999		