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	145924	A. BUILDING _____ B. WING _____	C 03/16/2007

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

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F 324	Continued From page 9 "01-21-07 11:30 PM Res[sic] found on floor in room by bed: skin tear on right elbow reopened MAEW(moves all extremities well). Denied hitting head VS 92.8 128/72 80 20..." "2-14-07, 8:00 AM Called to room per CNA. Resident noted on floor bruise noted to left side to temple. Skin tear to right elbow cleansed with normal saline steri strips applied. Resident complained pain at left hip when add [sic] and abduction resident yells out stating "its my hip" pillow and blanket placed for comfort, Perl(pupils equal and reactive to light) grips bilat(bilateral) strong and equal. Md.(Medical Doctor) notified, Poa(Power of Attorney) notified, ADON(Assistant Director of Nurses) aware of accident. ambulance called for transport." Physician's Order dated 2/14/07 directed R6 be sent to the hospital 8:30 AM., where the hospital diagnosed R6 with a left femoral neck fracture hip. Review of R6's care plan demonstrated the care plan was not revised after any of the falls leading up to the fall with the hip fracture. Interview with the DON on 3/13/07 at approximately 1:30 PM confirmed the care plan had not been revised. She stated, "We have done everything we could regarding R6, staff presence was increased and he was toileted every 2 hours..."	F 324		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210a) 300.1210a)4) 300.1210a)5) 300.1210b)6)	F9999		

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F9999	Continued From page 10 300.2210b)1) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. 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. a)4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. a)5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. b)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	F9999		

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F9999	Continued From page 11 and assistance to prevent accidents. Section 300.2210 Maintenance b) Each facility shall: 1) Maintain the building in good repair, safe and free of the following: cracks in floors, walls, or ceilings; peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering, such as tile or linoleum; loose handrails or railings; loose or broken window panes; and any other similar hazards. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. Based on observation, interview, and record review the facility failed to provide a safe ingress and egress to the "D" wing shower stall for one (R3) of four residents sampled for accidents and injuries. The facility also failed to provide timely training to all Certified Nursing Assistants (CNA'S) after this problem (that provided for potential injury to residents) was identified. In addition, facility staff failed to transfer a resident from the shower room into the shower stall safely. This failure resulted in an unsafe transfer which caused the resident to tip over in a shower chair and strike his head against the shower wall. The resident suffered a neck fracture that resulted in the resident's death. Findings include the following: The Physicians's Order sheet dated 2/01/07 showed R3 with diagnoses of Alzheimer's, Bi-Polar Disorder, and Legally Blind. The resident assessment dated 1/19/07 indicated R3 is	F9999		

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F9999	Continued From page 12	F9999		

cognitively impaired and needs assist with bathing and dressing. The resident assessment also showed R3's primary mode of transportation is the wheelchair. Falls Risk Assessment dated 1/12/07 showed R3 was a high risk for falls.

A letter from the facility titled "Re:(Regarding) Reportable incident: R3," and dated 2/8/07, showed R3 had a fall with a serious injury in the shower stall of "D" hall in the facility. The letter stated, "...Resident was in the shower room preparing to receive a shower. Resident was sitting in the shower chair. Staff was assisting Resident into the shower stall when the shower chair tipped backwards. Staff was trying to prevent the shower chair from tipping further when she slipped and the resident fell backwards striking his head on the wall...A few minutes lapsed and resident was noted to have signs of SOB(shortness of breath). Ambulance was called. Resident was transported to Resident room via shower chair and oxygen was immediately started....EMTS (Emergency Medical Technicians) arrived and Resident was transferred to (hospital emergency room)."

A hospital X-Ray report dated 2/8/07 demonstrated R3 had suffered a broken neck. The report stated "...There is a fracture subluxation of (Cervical) C6 on C7 with 25% ventral subluxation or spondylolisthesis of C6 on C7 with right unilateral facet joint fracture with first or subluxed locked right infra-articular facet of C6. Suspect compression fracture of the superior vertebral end plate of C7 and anterior corner fracture of C7 cervical vertebra..."

A hospital progress note signed dated 2/11/07 by Z5, Trauma Surgeon showed R3 died on 2/11/07.

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F9999	Continued From page 13 The note stated, "Trauma Surgery...Comfort measures taken since yesterday A.M (morning)...Found (without) heartbeat or respirations. Pronounced (pronounced dead) at 1:00 AM; family at bedside." Z5, Trauma Surgery Physician interviewed on 3/2/07 at approximately 1:30 PM confirmed R3 died of the fractured neck. Z5 stated, "...the cause of death for R3 was an unstable broken neck. That is the cause of death. R3 would have had difficulty expanding his lungs. R3 was already compromised with other illness. These secondary effects would be magnified by the broken neck. His respiratory status would have been compromised secondary to the fractured neck..." Interview with E11, CNA on 2/28/07 at approximately 2:00 PM confirmed she was with R3 when he fell over backward in the shower chair. E11 stated, "I went to get R3 about 6:30 AM on 2/8/07. I brought him into the shower room, he was already in the shower chair. I undressed him . I then commenced to putting him in the shower stall. I was facing R3 holding the arms of the shower chair. R3 was moving backwards. The back wheels (of the shower chair) went over the front of the ramp OK. As soon as the back wheels contacted the shower floor the wheel chair stopped rolling and started to tip backwards. The chair tipped all the way over backwards. I then lost my balance and fell forward into the shower. R3 ended up still sitting in the shower chair but the back of the shower chair was on the floor. R3's head was up against the shower wall and his chin was touching his chest. I asked R3 if he was OK-he said no...I walked out of the shower room and got the nurse	F9999		

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F9999	Continued From page 14 at the nurses station...." Review of the Facility Incident Report log showed a incident involving another resident R5, in the "D Wing" shower room. The report showed R5 had a "fall" on 2/5/07 in the shower room and ended up with an "abrasion and skin tear." Interview with E2, Director of Nurses (DON) on 2/28/07 at approximately 1:30 PM showed an inservice to address staff training for safe shower transfer that was held after the 2/5/07 incident involving R5. The DON stated the inservice was held on 2/5/07 and covered proper transfer of a resident in and out of the shower room and to utilize an extra staff person when needing extra help in transferring a resident in and out of the shower. Review of the inservice attendance sheet dated 2/5/07 demonstrated E11's name was not on the sheet. Interview with E11, CNA, on 2/28/07 at approximately 2:00 PM indicated she was off work the day of the inservice and did not receive the training before returning to work on 2/8/07. E11 stated, "I had not been in-serviced on safely moving residents in and out of the shower when the incident with R3 took place." Observation of the shower room on "D" hall on 2/28/07 at approximately 12:00 PM showed a shower stall, fitted with a floor insert, that brought the level of the shower stall floor even with the level of the bathroom floor. It was observed that approximately a 3/16" lip still partially obstructed the flush fit of the insert with the bathroom floor. E1, Administrator, at the time of the observation, stated the facility installed the insert on 2/16/07, after the incident with R3. E1 stated the floor	F9999		

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F9999	Continued From page 15 used to have a concrete ramp that was constructed to bridge the gap between the bathroom floor and the shower stall floor. Interview with E10, Maintenance Supervisor, on 3/2/07 at approximately 12:30 PM confirmed he was the person who installed the ramps. E10 stated, in part "I put the ramps in about 8 months ago. I was attempting to bridge the gap between the ledge and the shower floor. To make it easier to move the residents in and out of the shower. The original problem was the shower lip. The CNA's would have to lift the residents up and over the lip to move the residents in and out of the shower...I have not had any training in the construction of handicap accessible bathrooms or showers..." Interview with E15, CNA, on 2/28/07 at approximately 3:20 PM indicated that the shower ramp was not safe. E15 stated, "After taking residents in the shower room I felt the ramps were not safe. I would move the residents in and out sideways. (As instructed in the 2/5/07 inservice). Pulling the chairs(shower chairs) in and out frontways-The chair wheels would sometimes get hung up on the ramp. The shower chairs will tilt. I have expressed my opinion that the ramps were not safe but I don't remember who (to) exactly..." Interview with E14, CNA, on 2/28/07 at approximately 4:20 PM showed a concern for the safety of the shower ramp. E14 stated, "...I felt the ramp was unsafe because of the steep grade. I never told anyone..." Interview with E13, CNA on 2/28/07 at approximately 4:15 PM demonstrated she also	F9999		

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F9999	Continued From page 16 thought the shower room was unsafe. E13 stated, "I have felt that shower room unsafe. Because of the ramp the shower chairs did not come in or out smoothly. The chair (shower chair) has tipped on me but I always caught it in time. I have mentioned it to the DON that the shower ramp was unsafe. This was before R5 fell." Interview with R16, CNA, on 2/28/07 at approximately 3:40 PM confirmed an unsafe condition existed in the shower room. R16 stated further the facility was aware of the condition. R16 stated, "I felt the showers with the ramps were unsafe. I dropped a resident myself, R5, one day and one half before R3 fell. I told the DON myself they were unsafe. There was nothing to hold onto. I would avoid that shower room when I could but it has always been unsafe..." (A)	F9999		