STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation 1142700 (IL 54351) F157, F224, F253, F309, F314 1142666 (IL 54311) F309, F312, F314, F318	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157		11/4/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to promptly notify the physician for 1of 6 residents (R1) reviewed for physicain notification in the sample of 6. Findings include: The Minimum Data Set (MDS) dated 7/28/11 identifies R1 to be a 69 year old female admitted to the facility on 5/31/11 with diagnoses of Respiratory Failure, Anxiety, Tracheostomy, Gastrostomy, Atrial Fibrillation, Morbid Obesity, and Anemia. The MDS indicates she is alert/oriented and requires extensive to total assist of all Activities of Daily living (ADL's.). According to nurses noted dated 7/24/11 at 2pm, "Resident (R1) noted to have 2 areas on inner thighs R (right) 1.8cm x 1.2 x 0.2, L (left) 1.0 x 1.2 x 0.2 excoriation to thighs." The physician was notified and treatment orders obtained at the time. The next entry into the nurses notes relating to the pressure sores is on 7/29/11 at 1pm and documents "are to R inner thigh appears to be bigger in size 2.5 x 2.2 x 2" There is no documentation R1's physician was notified of the wounds deteriorating on 7/29/11. This was confirmed in interview with E2, Director of Nursing (DON), on 10/4/11 at 1:50pm. There is no further entries into the nurses notes until 8/4/11, 6 days later, which documents that "all previous orders dc"d (discontinued) new orders recieved." The August 2011 POS	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 157	Continued From page 2 reflects a treatment change dated 8/4/11 to both thigh wounds for Santyl and Silver Alginate after cleansing with normal saline daily and PRN (as needed.) There is no explanation as to why the physician was not notified previously when the decline was noted on 7/29/11, 6 days earlier. On 8/15/11, the nurses notes indicate R1 began exhibiting increased confusion, lethargy and elevated temperature. She was admitted to the hospital on 8/17/11 with pressure ulcers and cellulites, urinary tract infection and sepsis.	F 157		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility neglected to identify, assess, and treat multiple pressure ulcers for 1 of 4 residents (R4) reviewed for pressure ulcer treatment and prevention in the sample of 6. This failure resulted in R1 developing a fever, confusion, lethargy and wound odor, and R1 was sent to the emergency room, and found to have more pressure sores ranging from stage III's to necrotic areas than what the facility was aware of. R1 underwent debridement of the wounds on 8/25/11. Findings include:	F 224		11/4/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 224	Continued From page 3 The Minimum Data Set (MDS) dated 7/28/11 identifies R1 to be a 69 year old female admitted to the facility on 5/31/11 with diagnoses of Respiratory Failure, Anxiety, Tracheostomy, Gastrostomy, Atrial Fibrillation, Morbid Obesity, and Anemia. The MDS indicates she is alert/oriented and requires extensive to total assist of all Activities of Daily living (ADL's.). According to labs dated 7/6/11, R1 had a normal Total Protein 5.7 (Normal 5.5-8/3) and a low Albumin 2.4 (Normal 3.2-5.5). The care plan dated 6/13/11 identifies her to be at risk for skin breakdown due to decreased mobility, morbid obesity and diabetes. The care plan entry dated 8/12/11 identifies R1 to have three pressure wounds all in-house acquired on 7/24/11. The nurses noted dated 7/24/11 at 2pm document "Resident noted to have 2 areas on inner thighs R (right) 1.8cm x 1.2 x 0.2, L (left) 1.0 x 1.2 x 0.2 excoriation to thighs." The notes indicate treatment orders were received for Duoderm to left inner thigh. Nurses notes dated 7/29/11 at 1pm identifies a decline in wound status documenting "R inner thigh appears to be bigger in size 2.5 x 2.2 x 2" Resident and staff continues on going education for resident to be dry and T&P (turn and reposition) q (every) 1-2 (hours)." There is no documentation that the physician was notified on 7/29/11 at the time the decline was noted. No new treatment orders were obtained until 8/4/11. The Physician's Order Sheet (POS) shows a treatment change on 8/4/11 for Sanntyl and Silver Alginate after cleansing with normal saline daily and PRN (as needed) to the areas. The Treatment Administration Records (TAR's) for July 2011 show treatments ordered daily to R1's thighs were documented being done	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 224	Continued From page 4	F 224		

only 5 days of the 8 days from 7/24/11 through 7/31/11. The treatment for the wound on the right lateral leg which identified as "unstageable" is not on the TAR for July 2011 at all.

On 8/15/11 at 12:15pm, the nurses notes identify a condition change when R1 exhibited some lethargy with confusion "possibly related to Percocet" and the physician was called and ordered a reduction in the Percocet. There are no vitals recorded in the nurses notes or no evidence R1 was assessed for anything other than overmedication from the Percocet. The nurses also neglected to monitor R1's wounds toward the effectivenss of the new treatment as the next entry into the nurses notes is on 8/17/11.

The nurses notes on 8/17/11 at 9:30am indicate R1's confusion continued along with refusing medications/poor intake, urine dark brown and "wounds bilateral lower legs drng (draining) foul smelly dark drng" with staff reporting that resident isn't herself. Temperature is recorded as 100.1 degrees, Pulse 88, Respirations 22 and Blood Pressure 122/68. The physician was called and R1 was transported to the hospital emergency room. The facility neglected to monitor and thoroughly assess R1's pressure ulcers and change in condition for possible causative factors and neglected to monitor her body for further breakdown.

According to hospital HISTORY AND PHYSICAL dated 8/17/11, R1 presented to the emergency room with a large wound on the right lower extremities. Under EXTREMITIES, it documentes R1 to have "multiple wounds on the right lower extremities" and also on the right groin area. According to the wound care pictures, areas were identified on R1's buttocks, right calf, left lower extremity, right groin (underneath) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 224	Continued From page 5 right groin area. An OPERATIVE REPORT dated 8/25/11 implies "Patient was admitted with fever/sepsis." The Wound Noted from the Hospital identify R1 to have a total of 9 wounds present on admission varying stages from II's to necrotic areas. On 9/29/11 at 11am, Z3 (R1's physician) stated R1 definitely had more wounds at the hospital, and that she had develop more following her admission on 8/17/11. Z3 stated in "all fairness, he could not say there weren't added wounds on admission than what the facility had identified." On 10/6/11 at 9:40am, Z3 stated he reviewed the emergency notes and although the report identified "multiple" wounds, the report only identifies two, one on her inner thigh and one on her lower right leg. This conflicts with the facility's wound report that identifies R1 to have at least 3 wounds on discharge. Z3 agreed that assessment and monitoring with documentation would be important in wound care. Z3 stated he was very familiar with R1, described her as very non-compliant with care, and could be demanding at times. Z3 stated he did not look at the emergency room reports, and being a pneumonologist, he refers patients to wound care services. Z3 stated there was a lag between R1 being admitted, and when wound services did their assessments.	F 224		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253		11/4/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	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) COMPLETION DATE
F 253	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to provide an odor free environment, and clean resident care items necessary to maintain a comfortable, and sanitary interior for 3 of 6 residents (R4, R5, R6) in the sample of 6. Findings include: 1. On 9/7/11 during initial tour of the facility, the front lobby of the building had a pervasive foul odor that persisted throughout the day. This odor was also noted on 9/8/11 and on 9/9/11. 2. Odors were also identified throughout the day on 9/7/11 through 9/9/11 on the Ventilator Unit which was sprayed frequently with air freshener. 3. R4's bed was noted to have rails that were in poor condition with tape on them and the air hose to her air mattress was observed to be taped with medical tape. Interview with Z1, and Z2 (R4's family members), on 9/7/11 at 10am, and both stated the rails and hose have been like that for a while. Both Z1 and Z2 noted the odors as well.	F 253		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		11/4/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 309	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify/assess and monitor conditions changes for 2 of 6 residents (R1, R4) reviewed for change of conditon in the sample of 6. This failure resulted in R1 being transfer to the hospital after exhibiting an elevated temperature, lethargy and increased confusion for two days with no assessment or monitoring being done. R1 was admitted to the hospital with fever, Sepsis, Urinary tract infection, and Pressure ulcer with cellulitis. Findings include: 1. The Minimum Data Set (MDS) dated 7/28/11 identifies R1 to be a 69 year old female admitted to the facility on 5/31/11 with diagnoses of Respiratory Failure, Anxiety, Tracheostomy, Gastrostomy, Atrial Fibrillation, Morbid Obesity, and Anemia. The MDS indicates she is alert/oriented and requires extensive to total assist of all Activities of Daily living (ADL's.). According to the Physician's Order Sheet (POS) for August 2011, R1 received Seroquel 200mg every HS (bedtime), Percocet 5/325mg 2 tabs every 6 hours as needed (PRN) for pain, Xanax 0.5mg every 4 hours PRN for anxiety, Tylenol 325mg 2 tabs every 4 hours PRN for pain/fever along with other routine medications. A psychiatric note dated 7/24/11 documents her HS dose of Seroquel was increased to 300mg. There is no documentation in the nurses notes reflecting the increase in Seroquel, and no documentation regarding the effectiveness of the new dose, and/or possible adverse side effects	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 309	Continued From page 8	F 309		

with the change.

The nurse notes dated 7/24/11 indicate R1 developed 3 in-house acquired pressure sores and orders received for treatments.. There are no further entries in the nurses notes until 7/29/11 when the notes document that the pressure ulcers were noted to be larger. The next entry is on 8/4/11 when a new treatment order for a debriding agent was ordered for the pressure ulcers. Between 7/29/11 and 8/4/11, there are no notations in the nurses notes regarding either the Seroquel increase or the pressure ulcer.

At 12:15pm on 8/15/11, the notes states "Dr notified of pts (patients) lethargy et some confusion possibly related to Percocet. Dose (reduced) to 1 tab every 6 hours PRN." The nurses notes fail to include any assessment for causative factors other than the Percocet although the PRN medication administration sheet (MAR) for August 2011 documents that R1 only received the Percocet 1 time on 8/3/11, 8/8/11 and 8/10, twice on 8/4, 8/5/ and 8/9, none on 8/11 or 8/12 and only one time from 8/13 - 8/15/11. The MAR documented that R1 did receive Xanax 0.5mg daily from 8/3/11 through 8/15 with an additional dose given on 8/8/11 and 8/10/11. There is no vital signs documented for 8/15/11 or 8/16/11 following this identified condition change.

There is no evidence the nurses monitored R1's increased confusion, lethargy/fever following the entry on 8/15/11 until 8/17/11, two days later when the nurses notes dated 8/17/11 at 9:30am document "skin color pale, res (resident) confused, refuses to eat or drink, refuses to take meds, urine dark brown, wounds to bilat (bilateral) (lower) legs drgn (draining) foul smelly dark drng. staff states res not herself." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 309	Continued From page 9 Transfer sheet indicates nursing assessment at the time of transfer documents R1 in a level of consciousness change, not eating recently, urine dark amber, wounds getting worse, emesis x (times) 2 this am, pale" Vital signs recorded at 100.1 degrees, pulse 88, respirations 22 and blood pressure 122/68. Z3, R1's Physician, was notified and R1 was sent to the emergency room where she was diagnosed with urinary tract infection, sepsis, and Decubitus ulcer with surrounding cellulitis. According to the Facility Policy and Procedure on CONDITION CHANGE, "any staff member who notices a resident status change shall immediately notify the appropriate licensed personnel." and "After assessing the resident, the licensed personnel shall contact the physician immediately" with vital signs, signs/symptoms of chief complaint, etc. The policy continues to indicate that the notification of the appropriate individuals will be documented in the medical record with status changes reflected on the 24 hour report and followed for 72 hours. "Documentation on the 24 hour report does not replace documentation in the medical record." 2. The MDS dated 8/24/11 identifies R4 is a 23 year old female admitted to the facility on 11/14/05 with diagnoses of Sepsis, Encephalopathy, Gastrostomy Tube, Tracheostomy and Profound Mental Retardation. The MDS indicates R4 is totally dependent on staff for all activities of Daily Living (ADL's), is non-verbal and severely cognitively impaired. The care plan dated 8/31/11 identifies R4 to be dependent on staff for all ADL's due to brain injury from an ear infection.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 309	Continued From page 10 According to the POS for August 2011, R4 had an order for Levaquin 500mg every day for 5 days and Cortisporin ear gtts (drops) ii (2) to Left ear three times daily for 10 days written and implemented. There is no information and/or documentation of what symptoms R4 was exhibiting prior to the order being received. Nurses notes from 8/25/11 and 8/26/11 also fail to reflect any symptoms R4 could have had, if any, prior to the medication being ordered. On 9/8/11 at 3pm, E2, Director of Nursing said charting for condition changes that include medications are documented on an ANTIBIOTIC TRACKING sheet and provided one for R4 that was initiated on 8/27/11. There is no information as to what signs/symptoms R4 was exhibiting prior to the call to the physician for the antibiotics. The first entry documents only the temperature at 97.9 degrees with "O (no) drainage" documented under nursing interventions. On 8/28/11, again the temperature is documented at 98.1 with nursing interventions being check temp, monitor ear drainage. There is no indication as to whether R4 had drainage from her ear or not. According to R4's family members, Z1 and Z2, on 9/7/11 at 10am, R4 had a large amount of drainage from her ear days before an antibiotic was ordered on 8/27/11. Both family members also state R4's face was swollen as well. Z1 stated R4 has frequent ear infections. There is no indication in the clinical record that R4 had any of these symptoms described by R4's mother although the physician was called by nursing and an antibiotic was ordered. The ANTIBIOTIC TRACKING sheet records temperatures from 8/28/11 until 8/31/11 when an entry written under "Infections related S/S (Signs/symptoms)" documented "ear	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 309	Continued From page 11 infection/dry". On 9/1/11, the infections related S/S has "Drainage" written in for R4's left ear but fails to include the amount of drainage, color and/or odor is any was present. The nurses notes dated 9/1/11 (no time documented) identifies R4 to have "scant amount of purulent drainage noted." On 9/2/11 7am to 7pm shift wrote "slight drainage L (left) ear." and the nurses notes dated 9/2/11 (no time recorded) again indicate a "small amount of purulent drainage noted on outer ear canal." The tracking report dated 9/3/11 also documented drainage but fails to include any additional information. On 9/4/11, the physician was again contacted and R4's ear drops were continued with no documentation as to why. The antibiotic tracking sheets documents R4's temperature from 9/4/11 until 9/8/11 with drainage identified as being "very little" on 9/6/11 (7am-7pm) and 9/8/11. There is no follow up evident after 9/8/11 even though R4 was still having some drainage from her left ear.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on interview, observations and record review, the facility failed to provide timely incontinent care for 2 of 2 residents (R4, R5) observed for incontinent care in the sample of 6.	F 312		11/4/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 312	Continued From page 12 Findings include: 1. The Minimum Data Set (MDS) dated 8/24/11 identifies R4 is a 23 year old female admitted to the facility on 11/14/05 with diagnoses of Sepsis, Encephalopathy, Gastrostomy Tube, Tracheostomy and Profound Mental Retardation. The MDS indicates R4 is totally dependent on staff for all activities of Daily Living (ADL's) and is "always incontinent of bladder and bowel." According to her care plan dated 8/24/11, R4 is at risk for skin breakdown due to decreased mobility and incontinence with interventions for staff to "Check for incontinence every 2 hours and clean and dry after every episode." On 9/7/11 at 10:40am, R4 was uncovered and observed to have a large bath towel rolled up, and stuffed between her legs in her perineal area. The towel was totally soaked with urine as was the paper pad that was under her. The paper pad was wet to all corners with urine. Interview with E4, Certified Nurses Aide (CNA), on 9/7/11 at 10:40am, and E4 said that R4 had changed after breakfast. Z1 (R4's family), and Z2 (R4's family) present in the room on 9/7/11 at 10:40am, and both stated they arrived to visit R4 at 9am and no staff had been in to check/change either resident in the room since they arrived. On 9/8/11 at 10:20am, R1 was again noted to be in bed with family at bedside. Z1 and Z2 stated no staff had been in to check/change R1 since they arrived at 9:00am when they arrived on 9/8/11. On 9/8/11 at 12:30pm, R1 was checked and changed as her incontinent pad which she was laying on was entirely soaked with urine. Z1 and Z2 stated that no staff had been in since they arrived at 9:00am on 9/8/11.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 312	Continued From page 13 On 9/8/11, E2, Director of Nursing (DON), agreed that using a towel as an incontinent pad was inappropriate. E2 also stated staff responsible for R1 that morning reported giving her a bedbath at 9:30am. This conflicts with interviews of Z1and Z2, and observations done throughout the morning. 2. According to the Admission Sheet, R5 is a 48 year old female admitted to the facility on 12/7/06 with diagnoses of Down's Syndrome, Tracheostomy, Gastrostomy Tube, and Respiratory Failure. The MDS dated 6/21/11 indicates R5 is totally dependent on staff for all ADL's and is always incontinent of bowel and bladder. The Care Plan dated 7/4/11 identifies her to be at risk for skin breakdown due to decreased mobility and incontinence. The interventions document staff are to keep her skin clean and dry, check for incontinence every 2 hours and clean/dry after every episode among others. The care plan indicates she has no pressure ulcers at this time. On 9/7/11 at 10am, R5 was laying in bed with the head of the bed elevated. Z1, and Z2 stated they arrived at 9am 0n 9/7/11, and no staff has been in to check/change either resident in the room since they arrived. R5 was observed in the same position at 10:20am, 11am, and at 11:30am, her head was noted to be resting on the bed rail. R5 was noted to have two cloth incontinent pads under her. R5 had been incontinent of urine which went from her waist to mid thighs. The outer edge of the wet section had began to dry leaving a brown circle. R5 was noted to have deep red creases throughout both buttocks, hips, upper thighs and back but no open areas. Z1, and Z2 confirmed the	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 312	Continued From page 14 observations that no staff had come in to check/change R5 since 9am on 9/7/11.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to identify, assess, treat and provide preventative measures for 4 of 4 residents (R1, R4, R5, R6) reviewed for pressure ulcer treatment and prevention in the sample of 6. This failure resulted in a 6 day delay in notifying the physician for a treatment change when R1's pressure sore was identified to be bigger and eventually developed drainage. Findings include: 1. The Minimum Data Set (MDS) dated 7/28/11 identifies R1 to be a 69 year old female admitted to the facility on 5/31/11 with diagnoses of Respiratory Failure, Anxiety, Tracheostomy, Gastrostomy, Atrial Fibrillation, Morbid Obesity, and Anemia. The MDS indicates she is alert/oriented and requires extensive to total assist of all Activities of Daily living (ADL's.).	F 314		11/4/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 314	Continued From page 15	F 314		

According to labs dated 7/6/11, R1 had a normal Total Protein 5.7 (Normal 5.5-8/3) and a low Albumin 2.4 (Normal 3.2-5.5). The care plan dated 6/13/11 identifies her to be at risk for skin breakdown due to decreased mobility, morbid obesity and diabetes. The care plan entry dated 8/12/11 identifies R1 to have three pressure wounds all in-house acquired on 7/24/11.

The nurses noted dated 7/24/11 at 2pm document "Resident noted to have 2 areas on inner thighs R (right) 1.8cm x 1.2 x 0.2, L (left) 1.0 x 1.2 x 0.2 excoriation to thighs." The notes indicate orders were received for Duoderm to left inner thigh, right inner thigh "santyl and DD (dry dressing)." The next entry into the nurses notes relating to the pressure sores is on 7/29/11 at 1pm and documents "are to R inner thigh appears to be bigger in size 2.5 x 2.2 x 2" Resident and staff continues on going education for resident to be dry and T&P (turn and reposition) q (every) 1-2 (hours)." There is no documentation in the nurses notes the physician was notified of the wound deteriorating.

The only other documentation of the wounds is on the weekly SKIN INTEGRITY REPORT - PRESSURE SORES which identifies both areas on the thighs as stage II's and an area on the right lateral leg noted also on 7/24/11 as an "unstageable" measuring 1.3cm x 1.2cm x 0.2cm depth.

The Treatment Administration Records (TAR's) for July 2011 document treatments ordered daily to R1's thighs were documented being done only 5 days of the 8 days from 7/24/11 through 7/31/11. The wound on the right lateral leg identified as "unstageable" is not on the TAR for July 2011 at all for treatments.

Review of the Physician's Order Sheet (POS)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 314	Continued From page 16	F 314		

includes an order dated 7/31/11 to insert a urinary catheter until wounds are healed, but is not documented in the nurses notes.

On 8/4/11, the August 2011 POS reflects a treatment change to both thigh wounds for Santyl and Silver Alginate after cleansing with normal saline daily, and PRN (as needed) 6 days after the decline was documented in the nurses notes.

The next entry into the nurses notes is dated 8/15/11 at 9am, and documents the facility nurses were attempting to get consent from family to call in Wound Specialists. At 12:15pm on 8/15/11, the nurses notes identify R1 exhibiting some lethargy with some confusion "possibly related to Percocet." No further assessment of wound status toward effectiveness of the new treatments is documented in the nurses notes and no vitals recorded.

The next entry into the nurses notes is on 8/17/11. The nurses notes dated 8/17/11 at 9:30am indicate R1's confusion continued along with refusing medications and poor intake, urine dark brown and the "wounds bilateral lower legs drng (draining) foul smelly dark drng" with staff reporting that resident isn't herself. Temperature is recorded as 100.1 degrees. The physician was called, and R1 was transported to the hospital emergency room. The nurses notes have no documentation of the wounds and/or drainage since 8/15/11.

According to hospital HISTORY AND PHYSICAL dated 8/17/11, R1 presented to the emergency room with a large wound on the right lower extremities. Under EXTREMITIES, it documents R1 to have "multiple wounds on the right lower extremities" and also on the right groin area. "For details, please see the pictures from the wound care note." The assessment identifies

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 314	Continued From page 17	F 314		

the areas a "Decubitus ulcer with surrounding cellulitis." According to the wound care pictures, areas were identified on R1's buttocks, right calf, left lower extremity, right groin (underneath) and right groin area. An OPERATIVE REPORT dated 8/25/11 implies "Patient was admitted with fever/sepsis. Patient has multiple lower extremity ulcers. The ulcers were of varying stages, including one with black eschar, indicating need for debridement."

The facility's documentation failed to consistently document all areas present at the time of discharge to the emergency room and failed to adequately identify the status including stages the wounds were currently.

On 8/22/11, measurements recorded on 8//22 by the hospital on admission wounds identify 9 wounds on admission. 1) Lateral underbelly - 1.4cm x 1/1cm pink moist 2) Left Posterior Calf 2cm x 1cm scabby to outer aspect, moist pink/yellow tissue, 3) Left lateral calf - superior wound 4cm x 3.5cm (entire wound) 1.5cm x 1.5cm yellow tissue and 1cm x 1cm pink outer with depth of 0.25cm unstageable., 4) Right lateral calf 10cm x 9cm moist yellow tissue with 5% grey tissue unstageable 5) Right thigh 6cm x 3.5cm (entire wound) 1.5 x 2.5 yellow with black tissue noted some pink moist base noted. 6) Right thigh medial wound 2.5cm x 2.5cm yellow/green slough issue over pink moist tissue 7) Right thigh most medial posterior 6.5 x 8cm pink moist with yellow tissue noted 1.5cm depth. 8)Right lower thigh posterior 8cm x 5cm yellow tissue noted pink granulation noted 9) Right buttocks 2cm x 1cm and 1cm x .5cm. On 8/25/11, R1 underwent surgery for debridement of the wounds.

Interview of E2, Director of Nursing (DON), on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 314	Continued From page 18	F 314		

9/8/11 at 11:25am, and E2 stated that R1 was very non-compliant with turning and repositioning and did not like staff cleaning her up. E2 stated R1's wounds did get worse, they had gotten a wound consult, but stated she had no other documentation besides the nurses notes and weekly report dated 8/12/11. E2 stated R1 left the facility before the wound specialist saw her. E2 acknowledged also that the Care Plan failed to include any reference to her non-compliance to care. E2 also stated the facility had a wound nurse until just recently, but the wound nurse walked out, and didn't return. E2 states she suspects the wound nurse took documentation with her. On 10/4/11 at 2:16pm, E2 stated she had no other wound records to provide.

On 9/9/11 at 1:10pm, E5, Licensed Practical Nurse (LPN), said he had done treatments on R1's wound in the weeks prior to R1's discharge and stated she would refuse to cooperate with care at times. E5 stated he did R1's treatments sometimes 3-4 times per shift due to incontinence, but that the wound nurse did them during the week with him doing them on the weekend. E5 stated the facility got a urinary catheter order due to R1's wound and difficulty keeping the dressing dry. R1's refusal of care and urinary catheter is not incorporated into the pressure ulcer prevention plan.

Treatment sheets reviewed from 8/1/11 through 8/17/11 for the 7am shift document the wound treatments being done only one time daily with no PRN's documented as E5 indicated.

On 9/9/11 at 1pm, E4, Certified Nurses Aide (CNA), stated she cared for R1 frequently, that R1 often refused care, and was very difficult to deal with. E4 also stated R1 was frequently incontinent of bowel and bladder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 314	Continued From page 19 On 9/29/11 at 11am, Z3 (R1's physician) stated R1 definitely had more wounds at the hospital, and that she had developed more following her admission on 8/17/11. Z3 stated in "all fairness, he could not say there weren't added wounds on admission than what the facility had identified." Z3 agreed that assessment and monitoring with documentation would be important in wound care. Z3 stated he was very familiar with R1, that she was very non-compliant with care, and could be demanding at times. Z3 stated he did not look at the emergency room reports, and being a pneumonologist, he refers patients to wound care services. Z3 agreed that R1's morbid obesity was a main point of concern, but did acknowledge that the facility should have been monitoring her skin for additional sores due to her non-compliance. On 10/6/11 at 9:40am, Z3 stated he had reviewed the emergency notes, found that they documented multiple areas, but only identified 2 in the note; one by the catheter and the other on her right lower leg. Z3 did not know why they wouldn't have identified at least three as the facility had. Z3 stated he did not review the pictures of the 9 areas identified as present "on admission.", but stated he thought there was a "lag time between when she was admitted and the wound care assessment." According to the SKIN AND WOUND CARE POLICY AND PROCEDURE, it is the policy of the facility's to provide appropriate skin care to maintain or improve skin integrity. The policy indicate CNA's are to report hew skin care problems to a license nurse. This was not evident since R1 was admitted to the emergency room with more pressure ulcers that documented at the facility. The policy also indicates wounds	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 314	Continued From page 20	F 314		

will be documented on a wound assessment flow sheet and placed on the wound report each week. "Wound care related notes will be written on the back of the TAR (treatment administration record) each week." The facility failed to follow this policy as the only documentation of the wounds identified by the facility is initially, then on 7/29/11, but none documented when the nurses identified the wounds as odorous and deteriorating. The policy also indicates weekly interdisciplinary team meetings will be held to discuss wounds, status, treatment and further breakdown but no documentation was provided to document that R1's wounds were assessed as needed.

2. The MDS dated 8/24/11 identifies R4 is a 23 year old female admitted to the facility on 11/14/05 with diagnoses of Sepsis, Encephalopathy, Gastrostomy Tube, Tracheostomy and Profound Mental Retardation. The MDS indicates R4 is totally dependent on staff for all activities of Daily Living (ADL's) and is "always incontinent of bladder and bowel." According to her care plan dated 8/24/11, R4 is at risk for skin breakdown due to decreased mobility and incontinence with interventions for staff to "Check for incontinence every 2 hours and clean and dry after every episode" and "turning and repositioning per facility protocol" among others.

On 9/7/11 at 10:40am, R4 was uncovered and observed to have a large bath towel rolled up, and stuffed between her legs in her perineal area. The towel was totally soaked with urine as was the paper pad that was under her. The paper pad was wet to all corners with urine. Interview with E4, Certified Nurses Aide (CNA), on 9/7/11 at 10:40am, and E4 said that R4 had changed after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	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) COMPLETION DATE
F 314	Continued From page 21	F 314		

breakfast. Z1 (R4's family), and Z2 (R4's family) present in the room on 9/7/11 at 10:40am, and both stated they arrived to visit R4 at 9am and no staff had been in to check/change either resident in the room since they arrived.

On 9/8/11 at 10:20am, R1 was again noted to be in bed with family at bedside. Z1 and Z2 stated no staff had been in to check/change R1 since they arrived at 9:00am when they arrived on 9/8/11. On 9/8/11 at 12:30pm, R1 was checked and changed as her incontinent pad which she was laying on was entirely soaked with urine. Z1 and Z2 stated that no staff had been in since they arrived at 9:00am on 9/8/11.

On 9/8/11 during the daily meeting, E2, Director of Nursing (DON) stated staff responsible for R1 that morning reported giving R1 a bed bath at 9:30am. However, this conflicts with interview of Z1, and Z2, and observations done at the time. Observations done show no change in repositioning at least from 10:20am until 12:30pm on 9/8/11.

3. According to the Admission Sheet, R5 is a 48 year old female admitted to the facility on 12/7/06 with diagnoses of Down's Syndrome, Tracheostomy, Gastrostomy Tube, and Respiratory Failure. The MDS dated 6/21/11 indicates R5 is totally dependent on staff for all ADL's and is always incontinent of bowel and bladder. The Care Plan dated 8/31/11 identifies her to be at risk for skin breakdown due to decreased mobility and incontinence. The interventions document staff are to turn and reposition her according to their facility protocol, keep her skin clean and dry, check for incontinence every 2 hours and clean/dry after every episode and do weekly skin checks among

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	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) COMPLETION DATE
F 314	Continued From page 22	F 314		

others. The Care Plan indicates she has no pressure ulcers at this time.

On 9/7/11 at 10am, R5 was laying in bed with the head of the bed elevated. Z1, and Z2 stated they arrived at 9am on 9/7/11, and no staff has been in to check/change either resident in the room since they arrived. R5 was observed in the same position at 10:20am, 11am, and at 11:30am, her head was noted to be resting on the bed rail. R5 was noted to have two cloth incontinent pads under her. R5 had been incontinent of urine which went from her waist to mid thighs. The outer edge of the wet section had began to dry leaving a brown circle. R5 was noted to have deep red creases throughout both buttocks, hips, upper thighs and back but no open areas. Z1, and Z2 confirmed that no staff had come in to check/change and reposition R5 since they arrived at 9am 9/7/11.

According to the facility's policy on TURNING AND POSITIONING, all bedfast residents that do not currently have skin breakdown will be repositioned at least every 2 hours.

4. R6's Care Plan dated 8/25/11 documents he has pressure ulcers on his coccyx and left heal. Interventions indicate staff are to turn and reposition per facility policy, do weekly skin checks, monitor skin during care and report changes to nurses, provide treatments as ordered. The POS documents an order for treatments to the heels and coccyx/sacrum. The coccyx/sacrum order is to cleanse with normal saline, apply Santyl and Silver Alginate daily and as needed. Monitor for effectiveness. The Care Plan identifies the sacrum wound as measuring 11 cm x 6cm by 3.5cm depth.

On 9/7/11 during tour of the building at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 314	Continued From page 23 9:55am, R6 was observed in bed. He was rolled to his right side to observe his treatment site, and the wound packing fell out of his gaping pressure sore as he was turned over. There was no dressing present over the packing, and there was no dressing in the bed cloths. His wound appeared to have a large amount of drainage with some odor. According to the E15, Nurse, assisting with the observation, R6's treatment is done daily. E15 acknowledged that the packing was the only part of the dressing present on the area. According to R6's MDS dated 8/18/11, he is extensive assist of one staff for bed mobility and total assistance for all other activities of daily living. The MDS also indicates he has a urinary catheter and a colostomy. R6 diagnoses include osteomyelitis of the sacrum pressure ulcer. Admission sheet information identifies R6 to be a 59 year old male admitted on 8/11/11.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to provide adequate services, complete range of motion, appropriate adaptive devices for the prevention of	F 318		11/4/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	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) COMPLETION DATE
F 318	Continued From page 24	F 318		

contractures, and treatment of current contractures for 2 of 2 residents (R4, R5) reviewed for passive range of motion (PROMs) in the sample of 6.

Findings include:

1. The Minimum Data Set (MDS) dated 8/24/11 identifies R4 is a 23 year old female admitted to the facility on 11/14/05 with diagnoses of Sepsis, Encephalopathy, Gastrostomy Tube, Tracheostomy and Profound Mental Retardation. The MDS indicates R4 is totally dependent on staff for all activities of Daily Living (ADL's). The MDS also identifies R4 to have range of motion limitations identified upper and lower extremeties but recieves no PROM's. The Physician's Order Sheet (POS) for September 2011 has no PROMs orders on it nor does the care Plan include a program/plan to address R4's range of motion needs.

On 9/7/11 at 9:55am, R4 was in bed. She was noted to have severe contractures all four extremeties including her hands/foot drop. Interview of Z1 (R4's family, and Z2 (R4's family) on 9/7/11 at 9:55am, and both stated sometimes R4 has wash cloths in her hands, and sometimes she doesn't. Z1 and Z2 stated they were unsure whether R4 was recieving services toward her contractures, or not, but thought R4 was getting PROM's done. Z1 and Z2 also state R4 gets up in the chair very infrequently due to difficulty positioning due to her contractures.

The facility provided a VOLUNTARY MOVEMENT/ROM ASSESSMENT dated 12/14/10, 3/8/11, 6/1/11 and 8/24/11 that identified that R4 has limitations on both sides of the body, but was unable to provide any therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 318	Continued From page 25	F 318		

or restorative assessments including quarterly and monthly notes toward R4's contractures that identify R4's limitations, and that include a program plan to address these needs. The Care Plan also fails to identify R4's current contractures and the need for services.

On 9/8/11, E2, Director of Nursing, said R4 receives PROM's one time daily on second shift. On 9/8/11 at 3pm, E12, Certified Nurses Aide (CNA), identified R4 as one of two residents she does range of motion on.

On 9/9/11 at 1:40pm, E13, Physical Therapist, stated preferably range of motion exercises are done twice daily 7 days a week, and "the more you move them, the better off you are." E13 stated she does not do any measurements for the facility on ROM, but agreed that it would be the only way to measure maintenance, improvement, or decline.

The facility's policy entitled RANGE OF MOTION (ROM) indicates exercises will be provided for residents in need of exercises as identified by the Care Plan, in order to maintain, aide, or to prevent further decline. The facility has failed to follow it's policy to ensure that R4's range of motion needs are met consistently and appropriately.

2. According to the Admission Sheet, R5 is a 48 year old female admitted to the facility on 12/7/06 with diagnoses of Down's Syndrome, Tracheostomy, Gastrostomy Tube, and Respiratory Failure. The MDS dated 6/21/11 indicates R5 is totally dependent on staff for all ADL's and has range of motion limitations all four extremeties for which she receives PROMs. The POS indicates she is on bedrest. The Care Plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	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) COMPLETION DATE
F 318	Continued From page 26	F 318		

identifies PROMs as an intervention done daily but doesn't indicate to what extent her limitations are.

On 9/8/11 at 3pm, E12, CNA, was asked to perform range of motion exercises on R5. R5's hands were held tightly in a fist and R5 was noted to have contractutes of all four extremeties including severe foot drop bilaterally. E12 did three repititions on R5's shoulder, rotated her hand and wrist, ranged her fingers, but did not do range of motion on her elbow. E12 was asked about R5's hands, and whether they usually put something in them. E12 stated yes, although R5 didn't have anything in either hand at the time. R5's right hand was observed to have white moist looking skin in the palm area, and her left hand was noted to have small open areas where her nails dug into her palm. E12 continued to range R5's legs and failed to range her toes and all aspects of her knees. E12 did state R5 was difficult to do due to her contractures.

R5 was observed on 9/7/11 at 10am to have nothing in her hands to prevent her nails from digging into her palms.

Any assessments towards R5's range of motion limitations/contractures was requested from the E2, and a VOLUNTARY MOVEMENT/ROM ASSESSMENT was provided which documented quarterly reviews from from10/13/10 through 6/21/11 identifying only that R5 had limitations on both sides of the body. E2 did not provide any additional assessments towards limitations.

The facility's policy on Range of Motion exercises indicate that all joints will be ranged,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F 318	Continued From page 27 and repetitions will be between 5 and 10 times.	F 318		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210b) 300.1210d)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 which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 28 of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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)3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record 300.3240 Section Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by: Based on interview and record review, the facility failed to identify/assess and monitor condition changes for 2 of 6 residents (R1, R4) reviewed for change of conditon in the sample of 6. This failure resulted in R1 being transfer to the hospital	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 29	F9999		

after exhibiting an elevated temperature, lethargy and increased confusion for two days with no assessment or monitoring being done. R1 was admitted to the hospital with fever, Sepsis, Urinary tract infection, and Pressure ulcer with cellulitis.

Findings include:

1. The Minimum Data Set (MDS) dated 7/28/11 identifies R1 to be a 69 year old female admitted to the facility on 5/31/11 with diagnoses of Respiratory Failure, Anxiety, Tracheostomy, Gastrostomy, Atrial Fibrillation, Morbid Obesity, and Anemia. The MDS indicates she is alert/oriented and requires extensive to total assist of all Activities of Daily living (ADL's.).

According to the Physician's Order Sheet (POS) for August 2011, R1 received Seroquel 200mg every HS (bedtime), Percocet 5/325mg 2 tabs every 6 hours as needed (PRN) for pain, Xanax 0.5mg every 4 hours PRN for anxiety, Tylenol 325mg 2 tabs every 4 hours PRN for pain/fever along with other routine medications. A psychiatric note dated 7/24/11 documents her HS dose of Seroquel was increased to 300mg.

There is no documentation in the nurses notes reflecting the increase in Seroquel, and no documentation regarding the effectiveness of the new dose, and/or possible adverse side effects with the change.

The nurse notes dated 7/24/11 indicate R1 developed 3 in-house acquired pressure sores and orders received for treatments.. There are no further entries in the nurses notes until 7/29/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 30	F9999		

when the notes document that the pressure ulcers were noted to be larger. The next entry is on 8/4/11 when a new treatment order for a debriding agent was ordered for the pressure ulcers. Between 7/29/11 and 8/4/11, there are no notations in the nurses notes regarding either the Seroquel increase or the pressure ulcer.

At 12:15pm on 8/15/11, the notes states, "Dr notified of pts (patients) lethargy et some confusion possibly related to Percocet. Dose (reduced) to 1 tab every 6 hours PRN." The nurses notes fail to include any assessment for causative factors other than the Percocet although the PRN medication administration sheet (MAR) for August 2011 documents that R1 only received the Percocet 1 time on 8/3/11, 8/8/11 and 8/10, twice on 8/4, 8/5 and 8/9, none on 8/11 or 8/12 and only one time from 8/13 - 8/15/11. The MAR documented that R1 did receive Xanax 0.5mg daily from 8/3/11 through 8/15 with an additional dose given on 8/8/11 and 8/10/11. There is no vital signs documented for 8/15/11 or 8/16/11 following this identified condition change.

There is no evidence the nurses monitored R1's increased confusion, lethargy/fever following the entry on 8/15/11 until 8/17/11, two days later when the nurses notes dated 8/17/11 at 9:30am document "skin color pale, res (resident) confused, refuses to eat or drink, refuses to take meds, urine dark brown, wounds to bilat (bilateral) (lower) legs drgn (draining) foul smelly dark drng. staff states res not herself." The Transfer sheet indicates nursing assessment at the time of transfer documents R1 in a level of consciousness change, not eating recently, urine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 31	F9999		

dark amber, wounds getting worse, emesis x (times) 2 this am, pale" Vital signs recorded at 100.1 degrees, pulse 88, respirations 22 and blood pressure 122/68.

Z3, R1's Physician, was notified and R1 was sent to the emergency room where she was diagnosed with urinary tract infection, sepsis, and Decubitus ulcer with surrounding cellulitis.

According to the Facility Policy and Procedure on CONDITION CHANGE, "any staff member who notices a resident status change shall immediately notify the appropriate licensed personnel." and "After assessing the resident, the licensed personnel shall contact the physician immediately" with vital signs, signs/symptoms of chief complaint, etc. The policy continues to indicate that the notification of the appropriate individuals will be documented in the medical record with status changes reflected on the 24 hour report and followed for 72 hours. "Documentation on the 24 hour report does not replace documentation in the medical record."

2. The MDS dated 8/24/11 identifies R4 is a 23 year old female admitted to the facility on 11/14/05 with diagnoses of Sepsis, Encephalopathy, Gastrostomy Tube, Tracheostomy and Profound Mental Retardation. The MDS indicates R4 is totally dependent on staff for all activities of Daily Living (ADL's), is non-verbal and severely cognitively impaired. The care plan dated 8/31/11 identifies R4 to be dependent on staff for all ADL's due to brain injury from an ear infection.

According to the POS for August 2011, R4 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 32	F9999		

an order for Levaquin 500mg every day for 5 days and Cortisporin ear gtts (drops) ii (2) to Left ear three times daily for 10 days written and implemented. There is no information and/or documentation of what symptoms R4 was exhibiting prior to the order being received. Nurses notes from 8/25/11 and 8/26/11 also fail to reflect any symptoms R4 could have had, if any, prior to the medication being ordered.

On 9/8/11 at 3pm, E2, Director of Nursing said charting for condition changes that include medications are documented on an ANTIBIOTIC TRACKING sheet and provided one for R4 that was initiated on 8/27/11. There is no information as to what signs/symptoms R4 was exhibiting prior to the call to the physician for the antibiotics. The first entry documents only the temperature at 97.9 degrees with "O (no) drainage" documented under nursing interventions. On 8/28/11, again the temperature is documented at 98.1 with nursing interventions being check temp, monitor ear drainage. There is no indication as to whether R4 had drainage from her ear or not.

According to R4's family members, Z1 and Z2, on 9/7/11 at 10am, R4 had a large amount of drainage from her ear days before an antibiotic was ordered on 8/27/11. Both family members also state R4's face was swollen as well. Z1 stated R4 has frequent ear infections. There is no indication in the clinical record that R4 had any of these symptoms described by R4's mother although the physician was called by nursing and an antibiotic was ordered.

The ANTIBIOTIC TRACKING sheet records temperatures from 8/28/11 until 8/31/11 when an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 33 entry written under "Infections related S/S (Signs/symptoms)" documented "ear infection/dry." On 9/1/11, the infections related S/S has "Drainage" written in for R4's left ear but fails to include the amount of drainage, color and/or odor is any was present. The nurses notes dated 9/1/11 (no time documented) identifies R4 to have "scant amount of purulent drainage noted." On 9/2/11 7am to 7pm shift wrote "slight drainage L (left) ear." and the nurses notes dated 9/2/11 (no time recorded) again indicate a "small amount of purulent drainage noted on outer ear canal." The tracking report dated 9/3/11 also documented drainage but fails to include any additional information. On 9/4/11, the physician was again contacted and R4's ear drops were continued with no documentation as to why. The antibiotic tracking sheets documents R4's temperature from 9/4/11 until 9/8/11 with drainage identified as being "very little" on 9/6/11 (7am-7pm) and 9/8/11. There is no follow up evident after 9/8/11 even though R4 was still having some drainage from her left ear. (B) 300.610a) 300.1210a) 300.1210b) 300.1210d)2)3)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 34	F9999		

the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 35	F9999		

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.

Section 300.1220 Supervision of Nursing Services

b)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

d)2) All treatments and procedures shall be administered as ordered by the physician.

d)3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record

d)5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 36	F9999		

enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

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 regulations are not met as evidenced by:

Based on interview, observation, and record review, the facility failed to identify, assess, treat and provide preventative measures for 4 of 4 residents (R1, R4, R5, R6) reviewed for pressure ulcer treatment and prevention in the sample of 6. This failure resulted in a 6 day delay in notifying the physician for a treatment change when R1's pressure sore was identified to be bigger and eventually developed drainage.

Findings include:

1. The Minimum Data Set (MDS) dated 7/28/11 identifies R1 to be a 69 year old female admitted to the facility on 5/31/11 with diagnoses of Respiratory Failure, Anxiety, Tracheostomy, Gastrostomy, Atrial Fibrillation, Morbid Obesity, and Anemia. The MDS indicates she is alert/oriented and requires extensive to total assist of all Activities of Daily living (ADL's.). According to labs dated 7/6/11, R1 had a normal Total Protein 5.7 (Normal 5.5-8/3) and a low

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 37	F9999		

Albumin 2.4 (Normal 3.2-5.5). The care plan dated 6/13/11 identifies her to be at risk for skin breakdown due to decreased mobility, morbid obesity and diabetes. The care plan entry dated 8/12/11 identifies R1 to have three pressure wounds all in-house acquired on 7/24/11.

The nurses noted dated 7/24/11 at 2:00pm document, "Resident noted to have 2 areas on inner thighs R (right) 1.8cm x 1.2 x 0.2, L (left) 1.0 x 1.2 x 0.2 excoriation to thighs." The notes indicate treatment orders were received for Duoderm to left inner thigh. Nurses notes dated 7/29/11 at 1:00pm identify a decline in wound status documenting "R inner thigh appears to be bigger in size 2.5 x 2.2 x 2" Resident and staff continues on going education for resident to be dry and T&P (turn and reposition) q (every) 1-2 (hours)." There is no documentation that the physician was notified on 7/29/11 at the time the decline was noted. No new treatment orders were obtained until 8/4/11. The Physician's Order Sheet (POS) shows a treatment change on 8/4/11 for Sanntyl and Silver Alginate after cleansing with normal saline daily and PRN (as needed) to the areas.

The only other documentation of the wounds is on the weekly SKIN INTEGRITY REPORT - PRESSURE SORES which identifies both areas on the thighs as stage II's and an area on the right lateral leg noted also on 7/24/11 as an "unstageable" measuring 1.3cm x 1.2cm x 0.2cm depth.

The Treatment Administration Records (TAR's) for July 2011 document treatments ordered daily to R1's thighs were documented being done only

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 38	F9999		

5 days of the 8 days from 7/24/11 through 7/31/11. The wound on the right lateral leg identified as "unstageable" is not on the TAR for July 2011 at all for treatments.

Review of the Physician's Order Sheet (POS) includes an order dated 7/31/11 to insert a urinary catheter until wounds are healed, but is not documented in the nurses notes.

On 8/4/11, the August 2011 POS reflects a treatment change to both thigh wounds for Santyl and Silver Alginate after cleansing with normal saline daily, and PRN (as needed) 6 days after the decline was documented in the nurses notes.

The next entry into the nurses notes is dated 8/15/11 at 9am, and documents the facility nurses were attempting to get consent from family to call in Wound Specialists. At 12:15pm on 8/15/11, the nurses notes identify R1 exhibiting some lethargy with some confusion "possibly related to Percocet." No further assessment of wound status toward effectiveness of the new treatments is documented in the nurses notes and no vitals recorded.

The next entry into the nurses notes is on 8/17/11. The nurses notes dated 8/17/11 at 9:30am indicate R1's confusion continued along with refusing medications and poor intake, urine dark brown and the "wounds bilateral lower legs drng (draining) foul smelly dark drng" with staff reporting that resident isn't herself. Temperature is recorded as 100.1 degrees. The physician was called, and R1 was transported to the hospital emergency room. The nurses notes have no documentation of the wounds and/or drainage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 39 since 8/15/11. According to hospital HISTORY AND PHYSICAL dated 8/17/11, R1 presented to the emergency room with a large wound on the right lower extremities. Under EXTREMITIES, it documents R1 to have "multiple wounds on the right lower extremities" and also on the right groin area. "For details, please see the pictures from the wound care note." The assessment identifies the areas a "Decubitus ulcer with surrounding cellulitis." According to the wound care pictures, areas were identified on R1's buttocks, right calf, left lower extremity, right groin (underneath) and right groin area. An OPERATIVE REPORT dated 8/25/11 implies "Patient was admitted with fever/sepsis. Patient has multiple lower extremity ulcers. The ulcers were of varying stages, including one with black eschar, indicating need for debridement." The facility's documentation failed to consistently document all areas present at the time of discharge to the emergency room and failed to adequately identify the status including stages the wounds were currently. On 8/22/11, measurements recorded on 8//22 by the hospital on admission wounds identify 9 wounds on admission. 1) Lateral underbelly - 1.4cm x 1/1cm pink moist 2) Left Posterior Calf 2cm x 1cm scabby to outer aspect, moist pink/yellow tissue, 3) Left lateral calf - superior wound 4cm x 3.5cm (entire wound) 1.5cm x 1.5cm yellow tissue and 1cm x 1cm pink outer with depth of 0.25cm unstageable., 4) Right lateral calf 10cm x 9cm moist yellow tissue with 5% grey tissue unstageable 5) Right thigh 6cm x 3.5cm (entire wound) 1.5 x 2.5 yellow with black	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 40	F9999		

tissue noted some pink moist base noted. 6) Right thigh medial wound 2.5cm x 2.5cm yellow/green slough issue over pink moist tissue 7) Right thigh most medial posterior 6.5 x 8cm pink moist with yellow tissue noted 1.5cm depth. 8)Right lower thigh posterior 8cm x 5cm yellow tissue noted pink granulation noted 9) Right buttocks 2cm x 1cm and 1cm x .5cm. On 8/25/11, R1 underwent surgery for debridement of the wounds.

Interview of E2, Director of Nursing (DON), on 9/8/11 at 11:25am, and E2 stated that R1 was very non-compliant with turning and repositioning and did not like staff cleaning her up. E2 stated R1's wounds did get worse, they had gotten a wound consult, but stated she had no other documentation besides the nurses notes and weekly report dated 8/12/11. E2 stated R1 left the facility before the wound specialist saw her. E2 acknowledged also that the Care Plan failed to include any reference to her non-compliance to care. E2 also stated the facility had a wound nurse until just recently, but the wound nurse walked out, and didn't return. E2 states she suspects the wound nurse took documentation with her. On 10/4/11 at 2:16pm, E2 stated she had no other wound records to provide.

On 9/9/11 at 1:10pm, E5, Licensed Practical Nurse (LPN), said he had done treatments on R1's wound in the weeks prior to R1's discharge and stated she would refuse to cooperate with care at times. E5 stated he did R1's treatments sometimes 3-4 times per shift due to incontinence, but that the wound nurse did them during the week with him doing them on the weekend. E5 stated the facility got a urinary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 41	F9999		

catheter order due to R1's wound and difficulty keeping the dressing dry. R1's refusal of care and urinary catheter is not incorporated into the pressure ulcer prevention plan.

Treatment sheets reviewed from 8/1/11 through 8/17/11 for the 7am shift document the wound treatments being done only one time daily with no PRN's documented as E5 indicated.

On 9/9/11 at 1pm, E4, Certified Nurses Aide (CNA), stated she cared for R1 frequently, that R1 often refused care, and was very difficult to deal with. E4 also stated R1 was frequently incontinent of bowel and bladder.

On 9/29/11 at 11am, Z3 (R1's physician) stated R1 definitely had more wounds at the hospital, and that she had developed more following her admission on 8/17/11. Z3 stated in "all fairness, he could not say there weren't added wounds on admission than what the facility had identified." Z3 agreed that assessment and monitoring with documentation would be important in wound care. Z3 stated he was very familiar with R1, that she was very non-compliant with care, and could be demanding at times. Z3 stated he did not look at the emergency room reports, and being a pneumonologist, he refers patients to wound care services. Z3 agreed that R1's morbid obesity was a main point of concern, but did acknowledge that the facility should have been monitoring her skin for additional sores due to her non-compliance. On 10/6/11 at 9:40am, Z3 stated he had reviewed the emergency notes, found that they documented multiple areas, but only identified 2 in the note; one by the catheter and the other on her right lower leg. Z3 did not know why they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 42	F9999		

wouldn't have identified at least three as the facility had. Z3 stated he did not review the pictures of the 9 areas identified as present "on admission.", but stated he thought there was a "lag time between when she was admitted and the wound care assessment."

According to the SKIN AND WOUND CARE POLICY AND PROCEDURE, it is the policy of the facility's to provide appropriate skin care to maintain or improve skin integrity. The policy indicate CNA's are to report new skin care problems to a license nurse. This was not evident since R1 was admitted to the emergency room with more pressure ulcers that documented at the facility. The policy also indicates wounds will be documented on a wound assessment flow sheet and placed on the wound report each week. "Wound care related notes will be written on the back of the TAR (treatment administration record) each week." The facility failed to follow this policy as the only documentation of the wounds identified by the facility is initially, then on 7/29/11, but none documented when the nurses identified the wounds as odorous and deteriorating. The policy also indicates weekly interdisciplinary team meetings will be held to discuss wounds, status, treatment and further breakdown but no documentation was provided to document that R1's wounds were assessed as needed.

2. The MDS dated 8/24/11 identifies R4 is a 23 year old female admitted to the facility on 11/14/05 with diagnoses of Sepsis, Encephalopathy, Gastrostomy Tube, Tracheostomy and Profound Mental Retardation. The MDS indicates R4 is totally dependent on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 43	F9999		

staff for all activities of Daily Living (ADL's) and is "always incontinent of bladder and bowel." According to her care plan dated 8/24/11, R4 is at risk for skin breakdown due to decreased mobility and incontinence with interventions for staff to "Check for incontinence every 2 hours and clean and dry after every episode" and "turning and repositioning per facility protocol" among others.

On 9/7/11 at 10:40am, R4 was uncovered and observed to have a large bath towel rolled up, and stuffed between her legs in her perineal area. The towel was totally soaked with urine as was the paper pad that was under her. The paper pad was wet to all corners with urine. Interview with E4, Certified Nurses Aide (CNA), on 9/7/11 at 10:40am, and E4 said that R4 had changed after breakfast. Z1 (R4's family), and Z2 (R4's family) present in the room on 9/7/11 at 10:40am, and both stated they arrived to visit R4 at 9am and no staff had been in to check/change either resident in the room since they arrived.

On 9/8/11 at 10:20am, R1 was again noted to be in bed with family at bedside. Z1 and Z2 stated no staff had been in to check/change R1 since they arrived at 9:00am when they arrived on 9/8/11. On 9/8/11 at 12:30pm, R1 was checked and changed as her incontinent pad which she was laying on was entirely soaked with urine. Z1 and Z2 stated that no staff had been in since they arrived at 9:00am on 9/8/11.

On 9/8/11 during the daily meeting, E2, Director of Nursing (DON) stated staff responsible for R1 that morning reported giving R1 a bed bath at 9:30am. However, this conflicts with interview of Z1, and Z2, and observations done at the time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 44 Observations done show no change in repositioning at least from 10:20am until 12:30pm on 9/8/11. 3. According to the Admission Sheet, R5 is a 48 year old female admitted to the facility on 12/7/06 with diagnoses of Down's Syndrome, Tracheostomy, Gastrostomy Tube, and Respiratory Failure. The MDS dated 6/21/11 indicates R5 is totally dependent on staff for all ADL's and is always incontinent of bowel and bladder. The Care Plan dated 8/31/11 identifies her to be at risk for skin breakdown due to decreased mobility and incontinence. The interventions document staff are to turn and reposition her according to their facility protocol, keep her skin clean and dry, check for incontinence every 2 hours and clean/dry after every episode and do weekly skin checks among others. The Care Plan indicates she has no pressure ulcers at this time. On 9/7/11 at 10am, R5 was laying in bed with the head of the bed elevated. Z1, and Z2 stated they arrived at 9am on 9/7/11, and no staff has been in to check/change either resident in the room since they arrived. R5 was observed in the same position at 10:20am, 11am, and at 11:30am, her head was noted to be resting on the bed rail. R5 was noted to have two cloth incontinent pads under her. R5 had been incontinent of urine which went from her waist to mid thighs. The outer edge of the wet section had began to dry leaving a brown circle. R5 was noted to have deep red creases throughout both buttocks, hips, upper thighs and back but no open areas. Z1, and Z2 confirmed that no staff had come in to check/change and reposition R5 since they	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 45 arrived at 9am 9/7/11. According to the facility's policy on TURNING AND POSITIONING, all bedfast residents that do not currently have skin breakdown will be repositioned at least every 2 hours. 4. R6's Care Plan dated 8/25/11 documents he has pressure ulcers on his coccyx and left heal. Interventions indicate staff are to turn and reposition per facility policy, do weekly skin checks, monitor skin during care and report changes to nurses, provide treatments as ordered. The POS documents an order for treatments to the heels and coccyx/sacrum. The coccyx/sacrum order is to cleanse with normal saline, apply Santyl and Silver Alginate daily and as needed. Monitor for effectiveness. The Care Plan identifies the sacrum wound as measuring 11 cm x 6cm by 3.5cm depth. On 9/7/11 during tour of the building at 9:55am, R6 was observed in bed. He was rolled to his right side to observe his treatment site, and the wound packing fell out of his gaping pressure sore as he was turned over. There was no dressing present over the packing, and there was no dressing in the bed cloths. His wound appeared to have a large amount of drainage with some odor. According to the E15, Nurse, assisting with the observation, R6's treatment is done daily. E15 acknowledged that the packing was the only part of the dressing present on the area. According to R6's MDS dated 8/18/11, he is extensive assist of one staff for bed mobility and	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145289	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF BELLEVILLE	**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) COMPLETION DATE
F9999	Continued From page 46 total assistance for all other activities of daily living. The MDS also indicates he has a urinary catheter and a colostomy. R6 diagnoses include osteomyelitis of the sacrum pressure ulcer. Admission sheet information identifies R6 to be a 59 year old male admitted on 8/11/11. (B)	F9999		