STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146079	A. BUILDING _____ B. WING _____	C 02/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF CARBONDALE	**500 SOUTH LEWIS LANE CARBONDALE, IL 62901**

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F 323	Continued From page 4 wheelchair they were not removed from the wheelchair. According to E7 the wheelchair was locked prior to the move. E7's C.N.A Transfer Inservice Record signed and dated 10/21/2011 notes E7 received training in the application of gait belt and precautions for use, and in transfers.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.1210a) 300.1210b)5) 300.1210d)6) 300.3240a) 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	F9999		

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F9999	Continued From page 5 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. 5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are NOT MET as evidenced by: Based on observation, interview and record review the facility failed to ensure residents are properly and safely transferred, and injuries are prevented for 1 of 3 residents (R1), reviewed for safe and proper transfer in the sample of 3. The failure to properly and safely transfer R1 resulted in R1 sustaining a fracture to the left mid distal	F9999		

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F9999	Continued From page 6 fibula and fracture to the left anterior tibia. Findings include: R1 a 97 year old woman has resided in this facility since 9/16/2010, according to facility admission records of that date. The Physician Order Sheet dated 1/1/2012 lists R1's diagnoses to include Atrial Fib., Hallucinations and Headaches. A review of R1's record on 1/30/2012 notes an Incident Report of 1/20/2012 describing an incident that happened on 1/18/2012, R1 was complaining of pain and upon examination the lower left extremity was noted as red, swollen and deformed. R1's physician was notified and orders were received to have R1's lower left extremity x-rayed the following day. The x-ray report of 1/19/2012 notes a fracture of the mid distal fibula, and fracture of the anterior tibia. The facility's internal investigation documentation dated 1/20/2012 concludes the injury was sustained during transfer on 1/18/2012 as R1 was being assisted to bed after dinner. R1's most recent Minimum Data Set/MDS is dated 12/15/2010 and notes R1's functional status/transfers as extensive assistance and two persons physical assist. On 1/30/2012 at 8:45 am an interview was conducted with R1 about the injury to her leg. R1 was verbally responsive to the questions but was unable to tell the date or time of the injury. When questioned about the injury R1 stated her daughter told her that at her age "bones get brittle and break easily. With further questioning R1 stated "when I stood up it popped". When asked what popped R1 replied "my leg." R1 was asked if she stands by herself or if she can walk, she	F9999		

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F9999	Continued From page 7	F9999		

replied "no I don't." At 12:00 pm on 1/30/2012 R1 was observed sitting in a reclining chair in the dining room waiting for lunch, the left leg was extended and covered in a bandage wrap. When R1 was asked how she was doing R1 replied "OK". When R1 was asked if she was in pain R1 stated " no." At 3:05 pm on 1/30/2012 R1 was observed sitting in the reclining chair in her room her left leg was covered with a bandage wrap, she was awake and quiet and offered no complaint of pain.

On 1/30/2012 at 1:00 pm E2 (Director of Nurses) was interviewed concerning the injury to R1. During the interview E2 stated after interviewing staff and reviewing the facts determined the injury happened on 1/18/2012 after supper about 6:30 pm-7:30 pm "because before that time R1 had been up in her wheel chair and had not complained of pain, and the complaints of pain began after R1 was put to bed by E7 (Certified Nurse Aide/CNA). E2 stated according to E7, R1 reported to E7 as she was being put to bed that her leg felt like it was cut. E4 and E5 (Certified Nurse Aides/CNA) both worked with R1 on the day shift (6am-2 pm) on 1/18/2012, both were interviewed on 1/30/2012 (E4 at 1:45 pm and E5 at 1:35 pm) and when asked about the assistance R1 requires for transfers, E4 and E5 stated R1 requires two people to safely transfer her. E6 (Registered Nurse/RN) was interviewed on 1/30/2012 at 2:30 pm and during the interview E6 stated "on 1/18/2012 R1 was screaming in pain, this was about 9:00 pm and I gave her pain medication. When I asked her what hurt her she said my leg feels like it's been cut. When I examined her left leg the leg was bruised, her toes were swollen, and her ankle looked

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F9999	Continued From page 8	F9999		

displaced. I telephoned the physician and got orders to have her leg x-rayed in the morning, I found an ace wrap and immobilized the leg. I don't know if it happened that way but I think it got caught in the foot pedal of the wheelchair during transfer."

At 2:50 pm on 1/30/2012 E7 was interviewed about the injury to R1's leg. When E7 was asked about the amount of care R1 requires from staff E7 stated "she is total care." When asked if R1 was able to stand or walk E7 replied "no." When asked how many people was needed to safely transfer R1, E7 stated 2 but only 1 person has been doing it. When asked if she knows what R1's care plan notes about her needs and requirements, E7 stated "no, I have never seen a care plan." When E7 was asked to describe her actions on 1/18/2012 as she was putting R1 to bed E7 stated "I pivoted her when I put her to bed, she did not bear weight." When E7 was asked if she used a gait belt when transferring R1, E7 stated "no I did not use a gait belt". When asked if R1's wheel chair had foot pedals on it during the transfer E7 stated "yes." When E7 was asked how long she has worked at the facility E7 replied "I have worked here since October 2011 and I have worked different wings since I've been here". When asked what she did when she heard R1 scream out E7 stated I told the nurse who was in the hall passing medications, I looked at her leg and saw a purple spot (looked old) it was round and it was on the outer shin area."

Directly following the interview on 1/30/2011 at 3:15 pm E7 was asked to go to R1's room and demonstrate how she transferred R1 from the wheelchair to the bed on 1/18/2012. Observation

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F9999	Continued From page 9 was made of E7 using a wheelchair identical to the one R1 used on 1/18/2012 (leg pedals on), E7 rolled the wheelchair next to the bed, the foot rests on the wheelchair were facing the head of the bed and E7's back was to the head of the bed. E7 (by demonstration R1 was not used in the reenactment) put her arms around R1 in a bear hug fashion and reached around behind R1 using the waist band on the back of R1's pants lifted R1 and swung R1's buttock around to the center of the bed providing no support for R1's legs or feet. Once R1 was seated on the bed E7 bent down to move R1's feet and legs onto the bed. Although E7 lifted the foot pedals on the wheelchair they were not removed from the wheelchair. According to E7 the wheelchair was locked prior to the move. E7's C.N.A Transfer Inservice Record signed and dated 10/21/2011 notes E7 received training in the application of gait belt and precautions for use, and in transfers. (B)	F9999		