STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145924	A. BUILDING _____ B. WING _____	10/24/2012

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

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F 465	Continued From page 28 interview, the facility failed to ensure that two of two open flame gas dryer were free of dust and lint to prevent the potential of a fire. This has the potential to affect all 92 residents. The finding include: On 10-22-12 at 4:35 P.M. accompanied by the Maintenance Director, E28, and the Housekeeping Supervisor, E29, the two open flame gas dryers' heat exchangers had an accumulation of dust and lint. The gas Venturi tubes had dust and lint on them. Dust and lint were on the top of the drum compartment that is located below the heat exchanger. Dust and lint were on the back of the dryers and the exhaust ducts. E28 stated during the tour on 10-22-12 at 4:35 P.M. that he does not have a routine scheduled time to clean the top of the dryers. According to the facility's Centers for Medicare and Medicaid Services, form CMS-672 " Resident Census and Conditions of Residents" dated 10-23-12, 92 residents reside at the facility.	F 465		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 300.610a) 300.1210b) 300.1210d)5) 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	F9999		

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F9999	Continued From page 29 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 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis 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 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,	F9999		

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F9999	Continued From page 30 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 requirements were not met as evidenced by: Based on observation, record review and interview, the facility failed to provide services to prevent and treat pressure sores for one of five residents (R2) reviewed for pressure sores out of a sample of 19. Staff failed to assess accurately, promptly report and initiate treatment on a newly identified pressure sore, reposition and provide incontinence care in a timely manner, and provide a pressure relieving device in the chair. These failures contributed to a small open area developing into a Stage III pressure sore. Findings include: According to admission records and the October 2012 Physician's Order Sheet (POS), R2 has been at the facility since 2008, with multiple diagnoses including Vascular Dementia, Chronic Pain Syndrome, Neuropathy, Cerebrovascular Accident, Disfigurement of Neck, Osteoarthritis and Osteoporosis. The Minimum Data Set (MDS) dated 10/12/12 assesses R2 with severe cognitive impairment, requiring extensive to total assistance for activities of daily living, incontinence of bowel and bladder, and contractures of the upper extremities. On 9/21/12 R2 was assessed as high risk for skin	F9999		

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F9999	Continued From page 31	F9999		

breakdown.

On 10/21/12 at 10:00am, E10 (nurse) reported that R2 had a Stage III to Stage IV pressure sore. At 11:15am, a telephone order dated 10/21/12 was noted for a wet-to-dry dressing to the "open area" on the right buttocks. At that time, surveyor requested to observe the treatment plus any care provided for R2, including incontinence care. E10 stated that E2 (Director of Nursing) was going to assess the area. At 3:50pm, E7 (Certified Nurse Aide/CNA) was doing incontinence care for R2. No dressing was on the open area on the left buttock, and E7 stated that there was no dressing on when she started the incontinence care. The area was a deep, open, round crater. A shallow, irregular open area was on the right buttock. At 4:00pm on 10/21/12 E2 measured and did the wet-to-dry dressing for the left buttock. E2 stated the area measured 3cm (centimeters) by 3cm by 3cm deep, and confirmed this as a Stage III pressure sore. E2 did not measure the reddened open area on the right buttock. E2 stated according to her investigation, that a "pinpoint" area had been reported to the nurse "a week ago Saturday," and nothing was done at that time because R2 did have barrier cream. Then it was reported to E10 on 10/21/12 in report from the night shift that R2 had the open area. But the area was not reported to the Physician nor an order received for treatment until the morning of 10/21/12.

Daily Skilled Nurses Notes for 10/18/12 had "late entry" on the night shift of ". . . .Decub (decubiti's ulcer) to L' (left) buttock, small amount of drainage noted. Tx (treatment) nurse to assess for tx order." The next note dated 10/21/12 day

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shift by E10 states "Per AM report new opening R (right) buttocks small area with abrasion L' buttock, wet to dry dressing to R' buttocks." No other Nurses Notes prior to these dates address any open areas. E2 documented on 10/21/12 at 3:00pm the measurements for the left buttock area and "reddened surrounding area, sloughing noted with small amount of blood noted. . ."

The Treatment Records (TR) for 9/12 and 10/12 include orders for weekly skin checks on Wednesdays. The 9/12 TR shows no initials indicating that any skin checks were completed for the month. The 10/12 TR shows initials on 10/4 and 10/12/12 with an "I." E10 stated on 10/22/12 at 10:00am that "I" indicates "intact." E10 also stated that skin checks are marked off based on information from the CNAs, that the nurses do not actually do skin checks themselves. E2 stated on 10/24/12 at 1:00pm that skin checks are to be done by the nurses as designated on the TR for day of week and shift. E10 also confirmed that she did not know about the pressure sore until she was told about it in report from the night shift the morning of 10/21/12. That was when E10 called the Physician and got the treatment order. E10 stated she was not aware of the 10/18/12 Nurses Note and did not know why the area had not been reported to the Physician.

On 10/22/12 at 10:15am, E6 (CNA) transferred R2 to bed from the high-back wheelchair. No pressure relieving cushion was noted in the chair. E6 did incontinence care for a large loose bowel movement, heavily soiling the dressing on the left buttock area. The soiled dressing was removed and brownish serous drainage oozed from the

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area. E6 stated that R2 has had the open area on the left buttock for "at least two weeks." E6 stated that R2 was moved to the present room from another hall about two weeks ago, and that was when E6 started taking care of R2. E6 stated that R2 had the open area ever since she has been taking care of her, but that "it came up really quick."

On 10/23/12 at 9:45am, R2 was transferred from bed to the high-back wheelchair by E11 (CNA). No cushion or pressure relieving device was in the chair. R2 remained in the wheelchair without repositioning or a pressure relieving device from 9:45 a.m. until 11:15 a.m. (based on 15 minute observations), from 11:15 a.m. until 1:00 p.m. (based on 10 - 20 minute interval observations) and from 1:00 p.m. until 3:55 p.m. (based on 15 minute interval observations). At 3:55pm, R2 was transferred from the wheelchair to the bed by E13 (CNA). A large wet area was noted on the back of R2's pants. When changed, the incontinence brief was saturated with urine, and no dressing was covering the pressure sore. E11 stated on 10/24/12 at 9:10am that she got R2 up into the wheelchair "a little before 10" on 10/23/12, and that E11 took R2 to her room and "checked" her before taking her to the dining room. E11 stated that she checked R2 before lunch because R2 goes to Therapy.

The careplan dated 8/24/12 under risk for skin breakdown instructs staff to "use devices in bed/chair to relieve pressure. . . .keep skin dry and clean. . . Monitor and report all red areas, assess skin daily. . . .T & P (turn and position) at least every 2 hours, more frequently as needed when in bed and chair. . ."

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F9999	Continued From page 34 The undated facility policy and procedure for Skin Breakdown Risk Assessment includes the following: ". . .When a skin breakdown occurs, actions should include. . . a. The licensed nurse who is notified of an area of skin breakdown is responsible for completing and documenting a full body skin assessment at the time the breakdown is identified. b. The type, location and description of the breakdown should be documented . . .. The DON, designee or Treatment Nurse will notify the physician an also obtain treatment orders. . . . .Facility acquired skin breakdown may indicate a problem in the delivery of preventative skin care. . . ." B	F9999		