STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145388	A. BUILDING _____ B. WING _____	C 11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF OLNEY	**410 EAST MACK OLNEY, IL 62450**

(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 1556077/IL81291	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to respond to call lights/call light concerns in a timely manner for 3 of 10 residents (R5, R9, R7) reviewed for call lights in the sample of 11. Findings include: On 11/09/15 at 3:15PM, R5's call light was observed on and lit above her door. A continuous observation identified R5's light was on for 8 minutes and 30 seconds. During this observation, E1 (Administrator), E2 (Director of Nurses), E4 (Assistant Director of Nurses), and E8 (Activity Director) were observed to pass by the room without checking on R5. Immediately after each observation, this surveyor checked on each resident. On 11-5-15 at 1:45 p.m., R7 stated it is common to wait a "long time" for her call light to be answered adding she has watched the clock, but did not give specifics. R7 stated she has been incontinent of bowel due to waiting for assistance with the call light on.	F 241		

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

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F 241	Continued From page 1 Review of the Resident Council Minutes from September and October 2015 indicates those present voiced concerns with the nursing staff needing more CNA's on 2nd shift (2PM-10PM). The 09/24/15 Resident Council Concern Form signed by E8 (Activity Director) states the response is, "Just hired 2! 1 quit already hiring hiring hiring." The Resident Council Follow-Up section of the form states, "Talked to Residents about response to concern." On 11/09/15 from 4:10PM-4:20PM, R9 and R10 were interviewed. Each stated they attend the Resident Council Meetings and voiced concerns regarding the 2nd shift needing more CNA's at the September and October 2015 meetings. Each stated they specifically mentioned call lights and they have not received resolution information. R9 stated her call light has been on up to an hour and that she watches the clock. R9 added it never changes. On 11/09/15 at 3:15PM, E2 stated all staff are to answer call lights and she wants them answered within 3-5 minutes. On 11/09/15 at 5:00PM E1 stated call lights are to be answered within 3-5 minutes and any staff member can answer a light. During these interviews E2 stated E8 did inform her of the residents concerns regarding CNA's on the second shift and she is hiring. E1 and E2 each stated they were not aware that there was a specific concern regarding call lights. E1 stated there is a "break down in the system" with the department head getting the necessary information and she has discussed this with her consultant and E8. The Facility's February, 2012 Answering the Call Light policy states, General Guidelines "8. Answer the resident's call as soon as possible." A	F 241		

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F 241	Continued From page 2 Resident Roster dated 11/05/15, provided by E2, identifies R5-R7 as interviewable.	F 241		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		

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F 441	Continued From page 3 infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to prevent cross contamination during wound care for 1 of 2 residents (R4) reviewed for infection control in the sample of 11. Findings include: E7 (Registered Nurse) was observed performing wound care on R4 on 11/05/15 at 11:55AM. E7 entered the room with the dressing care supplies obtained from the Treatment Cart. During the wound care, E7 removed a soiled dressing from R4's right heel and picked up the Wound Cleanser with the contaminated gloved hand. E7 proceeded to spray the cleanser on to the heel and cleanse the area with the same gloved hand. E7 then reapplied a new dressing and reached into her pocket to obtain a pair of scissors and a pen. After using the pen, E7 placed the pen back in her pocket. E7 was not observed to change gloves at any time during this part of the observation. Immediately following the wound care completion, this surveyor asked E7 what she does with the Wound Cleanser. E7 stated the Wound Cleanser was a stock cleanser and will be placed back in the Treatment Cart. At this time, E3 (Licensed Practical Nurse-Wound Care Nurse) informed E7 that the Wound Cleanser could not go back into the Treatment Cart due to cross contamination.	F 441		