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HELIA HEALTHCARE OF CHAMPAIGN	**1915 SOUTH MATTIS STREET CHAMPAIGN, IL 61821**

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Complaint # 1566338/IL81610 no deficiency	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,	F 156		12/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 12/09/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility

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F 156	Continued From page 2 written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to display information about how to apply for Medicare and Medicaid benefits, and failed to display information about the state advocacy and protection network. These failures affect all 54 residents residing in the facility. Findings include: On 11/17/15 at 11:21 AM and 4:05 PM there were no postings or displays in the facility with information about how to apply for Medicare and Medicaid Benefits. There were no postings of information about the state advocacy and protection network (Equip for Equality). On 11/17/15 at 4:06 PM E1, Administrator, stated, "I know they (Medicare and Medicaid postings) are required, they used to be here (on the bulletin board)." On 11/19/15 at 3:40 PM, E1 stated, "This is the first time anyone has brought (Equip for Equality) to my attention." The facility's Resident Census and Condition of Residents report dated 11/17/15 documents 54 residents reside in the facility.	F 156		

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F 278	Continued From page 3	F 278		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to accurately assess one of eight residents (R1) reviewed for Minimum Data Set assessments in a sample of 14.	F 278		12/16/15

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F 278	Continued From page 4 Findings include: The Minimum Data Set (MDS) section M300 Current Unhealed Pressure Ulcers dated 11/3/15 documents R1 with two Stage 2 Pressure Ulcers and 2 Unstageable Pressure Ulcers. The MDS section M900 Healed Pressure Ulcers dated 11/3/15 documents R1 with zero Pressure Ulcers healed since the prior assessment. On 11/18/15 at 9:45am, R1 had an Unstageable Pressure Ulcer to the right and left sacrum which merged into one wound. The Pressure Wound Report dated 9/11/15 documents R1 with a closed Pressure Ulcer to the right gluteal buttock. The Pressure Wound Report dated 11/18/15 documents R1 with an Unstageable Pressure Ulcer present to the right and left sacrum on 11/1/15 and 11/6/15. On 11/18/15 at 2:15pm, E17 (MDS Coordinator) stated R1 had MDS assessments completed on 8/4/15 and 11/4/15. E17 stated on 9/11/15 R1's right gluteal Pressure Ulcer was resolved and healed. E17 stated at the time of the 11/4/15 assessment section M900 should be marked to reflect one Pressure Ulcer had healed and section M300 should be marked to reflect R1 had two Unstageable Pressure Ulcers and the two stage 2 Pressure Ulcers should be marked as zero.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		12/16/15

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F 279	Continued From page 5 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop a comprehensive fall care plan for one of four residents (R11) reviewed for falls in a sample of 14. Findings include: The Fall Care Plan dated 10/12/15 documents R11 with a history of falling related to generalized weakness with approaches that do not include the implementation of a scoop mattress. This Fall Care Plan documents implementation of a floor mat on 10/21/15. The Resident Post Fall Assessment documents R11 was found on the floor on the side of the bed on 10/21/15.	F 279		

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F 279	Continued From page 6 On 11/19/15 at 2:15pm, E3 (Director of Nursing) stated R11 was at risk for falls at the time of admission on 9/22/15. E3 stated a floor mat and scoop mattress were implemented upon admission. E3 verified a scoop mattress and floor mat should have been included in the care plan implemented on 10/12/15. The policy Falls Management dated July 2014 documents, "Resident's identified as high fall risk will have fall prevention addressed in the plan of care."	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to perform incontinence care in a manner to prevent cross contamination for one of four residents (R12) reviewed for incontinence care on the sample of 14. Findings include: R12's Physician Order Sheet dated 11/1/15 -	F 315		12/16/15

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F 315	Continued From page 7 11/30/15 documents a diagnosis of Alzheimer's Disease. R12's Minimum Data Set dated 9/8/15 documents that R12 is totally dependent on physical assist from staff for incontinence care. On 11/17/15 at 1:15pm, E10, Certified Nursing Assistant provided R12's incontinence care. R12 had smears of feces removed by E10 during incontinence care. E10 did not remove the soiled gloves. E10 then touched R14's hair, hand, side rail, periwash bottle, shirt and blanket. On 11/17/15 at 1:27pm, E10 stated "I forgot, I know I should have removed my gloves and cleaned my hands." The facility policy "Perineal Care" dated February 2012 documents the following: "Remove gloves and discard into designated container. Wash and dry your hands thoroughly. Reposition the bed covers. Make the resident comfortable."	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Failures at this level required more than one	F 323		12/16/15

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deficient practice statement.

A. Based on record review, observation and interview the facility failed to implement post fall interventions for one of four residents (R12) reviewed for falls in the sample of 14. This failure resulted in six additional falls with no injury.

B. Based on interview and record review the facility failed to supervise a resident after a behavior incident for one of three residents (R22) reviewed for abuse in a sample of 14.

C. Based on observation, interview and record review the facility failed to maintain an exit door alarm as designed, having the potential for unwitnessed resident exit from the facility, injury and exposure. This failure has the potential to affect five residents (R5 and R23 through R26) on the supplemental sample.

Findings include:

a. The Physician Order Sheet (POS) dated 11/1/15 - 11/30/15 for R12, documents the following diagnoses: Alzheimer's, Anemia, Hypertension, Restless Leg Syndrome,Weakness and Anxiety. The same POS documents R12 is receiving Hospice (end of life) Services.

The Minimum Data Set (MDS) dated 9/8/15 documents that R12 has severe cognitive impairment, does not ambulate, is dependent on staff for bed mobility and transfers.

R12's, Plan of Care dated 10/29/15 documents an intervention was put in place for a bed alarm on 3/18/15. This same Plan of Care was updated on 5/03/15, 5/11/15, 5/13/15, 5/25/15, 6/6/15,

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10/29/15 and 11/12/15 to include the following: make sure the alarm is working, placed out of resident's reach, turned on when resident is put in bed, and check the alarm every two hours on rounds.

A facility document titled "Assessment of Fall Risk" dated 11/12/15, R12 is assessed to be at high risk for falls.

The facility's "Accident and Incident" reports for R12 dated 5/03/15, 5/11/15, 5/13/15, 5/25/15, 6/6/15, 10/29/15 and 11/12/15 document R12's alarm was not sounding when R12 attempted to self transfer from bed.

On 11/17/15 at 1:30 pm, E10 and E11, Certified Nursing Assistants, had completed R12's transfer to bed and incontinence care. E10 pulled R12's 1/2 side rail to the highest position. R12's bed alarm sensor was attached to the side rail within R12's reach. On 11/18/15 at 8:19 am, R12's bed alarm was attached to the 1/2 side rail within R12's reach.

On 11/18/15 at 8:20 am, E3, Director of Nursing stated, "I see (R12'S) bed alarm on the side rail, it should have been placed out of his reach. It is an intervention to prevent him from self transfer without staff knowing."

The facility policy "Fall Management" dated 7/2014 documents the following: "It is the policy of (the facility) to assess and manage resident falls through prevention, investigation, and implementation and evaluation of interventions."
b. The Incident Report Form (initial and final) dated 9/15/15 documents R22 struck R6 on the head, no injuries noted. The Final Investigative

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F 323	Continued From page 10 Report dated 9/22/15 documents on 9/20/15 R22 propelled a wheelchair over to R6 and slapped R6's right cheek, no injuries noted. This report further documents when R22 was questioned as to why he struck R6 R22 stated, "because I wanted to." An order was obtained for a behavioral health evaluation for R22. The Care Plan dated 9/12/15 documents R22 at risk for increasing confusion and behaviors secondary to diagnosis of Dementia with Major Depressive Disorder. An update to this Care Plan dated 9/20/15 documents R22 went towards previous resident (R6) and slapped R6 in the head with approaches to include, "Monitor (R22) in regards to other resident (R6) and keep (R22) and (R6) apart, and arrange for evaluation and treatment at behavioral hospital." On 11/19/15 at 2:15pm, E3 (Director of Nursing) stated R22 had not displayed physical aggression towards other residents prior to the incidents on 9/15/15 and 9/20/15. E3 stated R22 specifically went after R6 on 9/20/15 and R22 stated R6 was slapped because he could with no other reason given. E3 stated after R22's 9/20/15 incident an order was received by Z3(Nurse Practitioner) for R22 to have lab work completed to determine any possible medical reasons for the change in behavior. E3 stated Z3 also requested R22 remain at the facility until the inpatient behavioral unit has an open bed for a thorough behavioral health evaluation. E3 stated after R22's 9/20/15 incident R22 was to have 15 minute checks for the first 72 hours, R22 and R6 were to remain separated and they were placed in separate dining rooms. E3 stated R22 was accepted for inpatient behavior health treatment on 9/30/15 returning to the facility on 10/12/15.	F 323		

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F 323	Continued From page 11 R22's Nurse's Notes 9/20/15 through 9/23/15 do not document 15 minute checks being completed. There were no 15 minute check forms for September 2015 in the Clinical Record. On 11/19/15 at 3:15pm, E3 stated 15 minute checks are present on a separate form or in the Nurse's Notes. E3 verified there was no documentation in Nurse's Notes or on a separate form to provide evidence R22 was monitored at 15 minute intervals after the 9/2015 behavioral episode for 72 hours. The Resident-to-Resident Altercation policy dated February 2012 documents for staff to document in the residents clinical record all interventions and their effectiveness. c. On 11/18/15 at 2:45 PM, the alarm installed on the egress door at the east end of C Wing did not sound when the door was opened repeatedly by E6, Maintenance Supervisor. This door was not supervised by any staff. On 11/18/15 at 2:45 PM, E6 stated, "I guess I will have to get down here and work on that." On 11/19/15 at 8:30 AM, the egress door alarm installed at the end of C Wing was not functional and the door was not supervised by any staff. On 11/19/15 at 11:35 AM E2, Director of Nursing stated, "We do have residents who are at high risk for elopement." On 11/19/15 at 3:40 PM E1, Administrator, stated, "I would have replaced it (door alarm) yesterday but I could not find a replacement until today."	F 323		

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F 323	Continued From page 12 The facility's undated "Residents at Risk for Elopement" list documents (R5, R23, R24, R25, and R26) as being at risk for elopement.	F 323		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain wallpaper and window blinds in a homelike manner, failed to maintain a handsink in a safe and easily cleanable manner, and failed to maintain window sills in a safe manner. These failures have the potential to affect three residents (R7, R12, and R19) on the sample of 12 residents reviewed for homelike environment and one resident (R27) on the supplemental sample. Findings include: 1. On 11/17/15 at 11:21 AM, the front edge of the handsink in the bathroom of resident room number 17 was easily moveable 2 inches up and down. There was a three-quarter inch gap between the rear of the sink and the wall behind the sink which was not easily accessible to allow cleaning behind the sink. The drain weir under the sink was visibly leaking and there was a plastic wastebasket under the weir collecting water from the drain leak. On 11/18/15 at 2:45 PM E6, Maintenance	F 465		12/16/15

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F 465	Continued From page 13 Supervisor, stated, "That resident has Schizophrenia and fills up the sink with water for soaking hands in it, and stands there leaning on the sink. The bracket probably needs to be tightened." 2. On 11/18/15 at 1:20 PM, the marble window sill in resident room number 23 had three full width, full thickness cracks across a two foot span. The center crack was buckled upwards one and one quarter inches, leaving sharp and jagged exposed edges . On 11/18/15 at 2:38 PM E6 acknowledged the condition of the window sill by stating, "Maybe I can beat that back down and put some marble putty in there." 3. On 11/18/15 at 2:35 PM, the window blinds in the facility's resident room number 21 were bent, tattered and gaping, preventing visual privacy from the exterior of the building. The marble window sill in this same room was broken on the corner leaving exposed sharp and jagged edges. On 11/18/15 at 2:35 PM E6 acknowledged the blinds and window sill and stated, "It looks like someone probably hit that sill with the bed. I can probably get that smoothed out with a sander." 4. On 11/18/15 at 2:40 PM, the wallpaper the facility's resident room number 25 was torn 53 inches long by two and one half inches wide, with tattered, frayed and irregular edges, on the wall at the head end of an occupied resident bed. On 11/18/15 E6, acknowledged the tear and stated, "There is a crack in the wall behind the wallpaper."	F 465		

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 ______	11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 14 The facility's "Room List" dated 11/16/15 documents R7, R12, R19, and R27 reside in the aforementioned resident rooms.	F 465		
F 468 SS=F	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to maintain corridor handrails in a secure manner. This failure has the potential to affect all 54 residents residing in the facility. Findings include: On 11/18/15 at 2:30 PM, the one and one half inch round wooden handrails in the facility's A Wing were loose and easily moveable throughout the length of the corridor with the exception of one section at the egress end of the corridor's east side. The handrails were sliding one-half inch back and forth along the extension bracket attached to the wall. On 11/18/15 at 2:30 PM, one section of one and one half inch round wooden handrail was loose and easily moveable, in the same manner as described in the previous paragraph, in the facility's B Wing between the laundry room and the nurse aide station. The ends of the wooden handrails had a forty-five degree angle miter cut with a short piece of rail, also cut at a forty-five	F 468		12/16/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 468	Continued From page 15 degree angle miter, attached to form a ninety degree angle return to the wall. The short return pieces were loose and able to swivel, leaving the sharp edges of the miter cuts exposed. These return pieces were loose in five locations in the facility's B Wing; in proximity to resident room numbers 17, 19, and 20, and next to the clean linen room, and next to the soiled utility room. The loose return piece next to resident room number 20 was also removable from the handrail, leaving an exposed nail. On 11/18/15 at 2:30 PM, one section of plastic one and one half inch by 6 inch handrail in the facility's C Wing was loose and easily moveable two inches up and down. This section of handrail was located between the maintenance office and a storage room. On 11/18/15 at 2:30 PM E6, Maintenance Supervisor stated, "I have tightened the (wooden) handrails before, I think they are loose on the bracket extension from the wall." E6 also stated, "I can remove the (plastic) cover from that rail and tighten the screw inside." E6 concluded, "I have nailed those return pieces back and it seems to last until someone runs into them." The Resident Census and Conditions of Residents Report, dated 11/17/15, documents 54 residents at the facility.	F 468		