STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003255	A. BUILDING: _____ B. WING _____	09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA SOUTHBELT HEALTHCARE	101 SOUTH BELT WEST BELLEVILLE, IL 62220

(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) COMPLETE DATE
S 000	Initial Comments Annual Health Statement of Licensure Violations	S 000		
S9999	Final Observations Licensure 1 of 2 300.610a) 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. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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	S9999	Attachment A Statement of Licensure Violations	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/02/19

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care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:
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, 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, interview and record review, the facility failed to assess and monitor residents that are high risk for skin breakdown. The facility failed to monitor turning, repositioning and provide effective pressure relieving interventions, to prevent the formation of pressure ulcers for 3 of 8 residents (R61, R199, R298) reviewed for pressure ulcers in the sample of 52.

This failure resulted in R199, developing a large, necrotic unstageable pressure ulcer to the left buttock and a large unstageable deep tissue

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S9999	Continued From page 2 injury to the right heel. Findings include: 1. R199's, Physician's Order Sheet, (POS), for 7/11/2019 through 9/06/2019, documents diagnose, in part, as General Muscle Weakness, Pneumonia, Malignant Neoplasm of Left Lung, and Anemia. The comprehensive Minimum Data Set (MDS), dated 7/13/2019, documents, R199, is; moderately impaired with cognition and decision making, requires extensive assistance with bed mobility and personal hygiene, and is incontinent of bowel and bladder. The MDS documents, R199, is at risk for skin breakdown. The Progress Notes, documents, R199, was admitted to the facility on 7/11/2019, at 2:43 PM. The Progress Note dated 7/12/2019, at 1:36 PM, documents, R199, had a skin check at that time. The Progress Note documents, in part, "no necrotic or open areas, left heel boggy but blanchable redness, will place order for (protective skin wipe) and podiatry consult per MD, (medical doctor), no open areas to the coccyx, barrier cream provided for protection". A Physician's Order, (PO), dated, 7/11/2019, documents, "(protective skin wipe) to coccyx every shift related to redness, and a PO, dated, 7/12/2019 documents, "(protective skin wipe) to left heel once a day and barrier cream every shift." The facility's Wound Log, dated 3/01 to 9/01/19 documents R199 developed a facility acquired, unstageable, DTPI (deep tissue pressure injury) to the coccyx measuring 1.5 cm (centimeter) X 2.0 cm and an unstageable callous to the left heel on 8/06/2019, measuring 0.4 cm X 0.2 cm. The	S9999		

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S9999	Continued From page 3 Wound Log has no date documented when R199 developed the DTPI to the coccyx. On 9/05/19 at 9:12 AM, R199 was in bed on his back, asleep with his legs drawn up and heels directly on the mattress. There were no pressure relieving boots or protectors on his feet. R199 was wearing gripper socks. There was a pressure relieving cushion in his wheel chair. The head of his bed was raised slightly, placing pressure to the coccyx area. On 9/06/19 at 10:42 AM, R199 was in bed on his back with the head of his bed raised 30 degrees. At that time, R199 reported he has a wound on his tailbone that has a dressing and one on his right heel. R199's heels were directly on the mattress. He had a dressing to the right heel and was wearing gripper socks on both feet. R199 complained of pain to his buttocks. On 9/06/19 at 11:02 AM R199 had both heels directly on the mattress. V6, Registered Nurse, (RN)entered the room. V6, RN removed the right sock and old dressing to the right heel that was dated 9/5/19. R199 had an open area to the outer right heel, with a small amount of serosanguinous drainage on the dressing. V6 cleansed the heel with normal saline (NS), applied hydrogel ointment and a new dressing. V6 removed the sock to the left foot. There was an unstageable, purple deep tissue injury (DTI) to left heel. There was no odor to either heel. V6 removed the dressing to the left buttock/coccyx area. There was a large unstageable pressure ulcer, with slough and necrosis. V6 reported a wound culture had been recently obtained of the area. V6 reported the open area looked better than it had the previous day. R199's wheelchair had a pressure relieving cushion, but had a nonskid pad	S9999		

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on top of it, with a folded incontinent pad on the top of the nonskid pad reducing the pressure relief of cushion.

On 9/06/19 at 1:16 PM, V13, Certified Nurse's Aide (CNA) stated to R199, "We have to turn you to get you off your bottom." R199 was repositioned on the left side with a pillow placed behind his back.

On 9/06/19 at 1:35 PM a pillow was placed between R199's knees, and a pillow was placed under the left outer ankle. V13 floated R199's heels on a pillow as well. R199 was wearing the same gripper socks.

On 9/10/19 at 11:36 AM, R199 was in bed on his back with both heels directly on the mattress. He was wearing only gripper socks. He was confused. There was no low air loss (LAL) mattress. R199's heels not floated.

On 9/10/19 at 12:47 PM Resident # 199 Per SWM report from V8, FNP' dated 9/9/19 "Left buttock pressure ulcer, 4X4 depth undetermined, 100% necrotic, depth obscured, with a moderate amount of exudate. LAL mattress ordered today."

On 9/10/19 at 1:24 PM, R199 was on his right side with LAL mattress in place. His heels were directly on mattress with gripper socks on.

The Progress Note, dated 8/4/2019 at 1:59 PM documents, "noted open area to right heel". No measurements are documented. There is no documentation V16, Physician was notified. There is no PO for this date in R199's POS. There is a PO dated 8/05/2019 that documents, "cleanse right lateral heel with NS and apply hydrogel, 4X4 and wrap with (elastic gauze

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wrap)".

The Wound History Report for R199 dated as first evaluated on 8/6/2019, documents R119 has the right heel is open, measuring 1.8 X 1.5 X 0.2 cm, facility acquired, pressure ulcer. There is no documentation of staging the area on the Report. The Wound History Report for R199 dated 9/6/2019 documents the pressure ulcer to the right heel measures 0.5 X 1.0 X 0.1 cm, which is some improvement.

The Progress Note for R199, dated 8/15/2019 at 3:31 AM documents, "noted small red area to right inner buttocks, not open at present, barrier cream applied." There are no measurements of the area documented. There is no documentation a physician was notified. There is no PO for that date related to the right inner buttocks.

The Wound History Report for R199, dated 8/29/2019, documents an open area to the coccyx, measuring 1.5 X 2.0 cm, unstageable, DTPI with induration, with necrotic eschar (dead infectious tissue) with no odor. The next Wound History Report for R199, dated 9/06/2019 documented R199 has an open, DTPI, with moderate exudate measuring 4.5 X 4.5 cm, with undetermined depth.

The Progress Note, dated 8/27/2019, documents, (R199) found to have DTI to coccyx with induration. DTI is 1.5 (cm) X 2.0 (cm) and blue in color. Induration is 4X4 and surrounds the DTI. MD notified. Barrier cream ordered to cover the area." A PO for R199 dated 8/27/2019 documents, "Barrier cream to buttock, coccyx and peri (perineal) area daily per shift and PRN (as needed)."

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The Wound History Report, dated 8/06/2019, for R199 documents a facility acquired, left heel open area, measuring 0.5 X 2.0 X UTD (undetermined) depth with necrotic eschar. "Type of wound: other-callous." There is no Progress Note dated 8/06/19 to address the open left heel.

The Progress Note dated 8/31/19 at 11:47 AM, documents, "Has dark area to bottom of left heel. This nurse applied (protective barrier wipe) to the area."

A Progress Note, dated 9/4/19 at 3:17 PM, documents V21, Physician ordered a special wound consult. The Progress Note documents, in part, "Has new small 0.5 X 0.5 X 0.1 cm open area to right coccyx. Treatment ordered for barrier cream. Right coccyx is now bright red and continues to have blue spot with induration around the blue spot. Will continue to treat areas with barrier cream and incontinence care. Awaiting orders from (V21, Physician).

The Progress Note dated 9/06/19 at 6:22 AM documents "new dressing to area to left buttock as ordered. Continues with purulent drainage moderate amount. Initiated ATB (antibiotic), resident has been T/P (Turned and repositioned) every 2 hours as resident will allow. Expresses pain when area touched."

The special wound consultant Report for R199, completed by V8, Nurse Practitioner on 9/09/2019 documents, in part, "Left buttock pressure ulcer, noted on 8/27. Unstageable, depth obscured, 100% (percent) necrotic 4 X 4 X UTD, exudate moderate amount, color-serosanguinous. LAL (low air loss) ordered today, nursing is repositioning every 2 hours and providing incontinence care.

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On 9/11/2019 at 1:51 PM, V21, stated, "The area to the sacrum (left buttock/sacral area) started out as a Stage I, small pressure wound, that is now infected. When it opened it became infected. I didn't know he was incontinent. He (R199) did not progress with therapy, and now is on custodial status as of 8/31/2019." V21 reported he was aware of the purple area to the left heel. V21 reported the facility should have been offloading R199's buttocks and feet to prevent pressure ulcers. The Report had no documentation related to R199's heels at all.

V21's Progress Note, dated 8/27/2019 documents R199 has a Stage 2 pressure ulcer to the right buttock, and a Stage 2 pressure ulcer to the right heel. V21's Progress Note, dated 9/06/2019 documents, in part that R199 has "decubitus ulcer of the coccygeal region, unspecified ulcer stage. (R199) has been having worsening wound to buttock, late last week there was some induration and was started on topical mupirocin (topical antibiotic ointment). Yesterday it broke open with large amount of purulent drainage. This was cultured and started on Doxycycline (oral antibiotic)."

R199's laboratory/wound culture of the coccyx, dated as collected 9/5/19 and result reported 9/09/2019 documents the open area contained a heavy growth of the bacteria, Escherichia coli. The culture report does not identify and document if bacteria is sensitive to Doxycycline.

R199's Care Plan, revised 8/6/2019 documents he is "at risk for skin breakdown due to weakness and decreased mobility. 8/6/2019 0.5 X1.0 X 0.1 right heel callous opened, treatment in place." The pressure ulcer of the coccygeal area and the

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S9999	Continued From page 8 left heel is not documented in R199's Care Plan. R199's laboratory report dated 8/27/19 documents a level of "Protein-6.7 g/dL (grams per deciliter) (normal=6/4-8.9), Serum albumin-3.3 g/dL (normal=3.5-5.7). The Report dated 9/5/19 documents "Protein 5.4(normal-6.4-8/9), Serum albumin 2.6 (3.5-5.7). R199's Treatment Administration Records (TAR) for 7/19, 8/19 and 9/19 documents weekly skin checks are completed but does not address the results. 2. R298's MDS, dated 9/04/2019 documents he was admitted to the facility on 8/28/19 and has moderate impairment with cognition, requires extensive assistance with bed mobility, transfers, personal hygiene, with a limited range of motion to one lower extremity. The MDS documents R298 is at risk for pressure ulcers and had none on admission. R298's POS for 8/10 through 9/10/2019 documents diagnose, in part, as Aftercare following joint replacement surgery, displaced fracture of base of neck of left femur (leg), and muscle weakness. On 9/05/19 at 10:29 AM, R298 had both feet on pillow, but his heels were not floated. R298 was moving the right leg in bed. R298 was on his back. On 9/06/19 at 11:19 AM, R298 remained in bed on his back. V6, RN entered the room for a skin check. R298's heels were directly on the mattress. There was a very large, dark purple DTI to R298's left heel. V6 reported it was new. R298	S9999		

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reported pain to his left leg. V6 stated, "I will call the doctor and get a treatment for it." R298 did not have a LAL mattress. V6 did not measure the dark purple area to the left heel.

On 09/10/19 at 11:40 AM, R298 was in his room in a wheelchair, asleep. There was no LAL mattress on the bed. A foam heel protector on his bed.

On 9/10/19 at 1:27 PM, R298 was in bed with HOB (head of bed) raised 30 degrees. His left foot has foam protective boot, but the right heel was directly on the mattress.

R298's Progress Note, dated 9/6/19 at 11:44 AM, documents "Purple area to left heel." A PO for 298 dated 9/6/2019 documents, "Cleanse left heel with NS and apply skin prep daily and PRN, Float heels when in bed. Multi-podus boots to left foot when OOB (out of bed)."

R298's Care Plan, dated as revised 9/06/2019 documents, in part, "Is at risk for skin breakdown related impaired mobility and muscle weakness. 9/6/9-left heel purple area 3.0 X 3.0 cm." There is no intervention in the care plan that addresses a turning or repositioning schedule or interventions related to R298's heels.

On 9/11/2019, V2, Director of Nursing (DON) reported the facility does not complete the Wound Healing Tracking form as outlined in their policy and procedure for pressure ulcer prevention and treatment. V2 stated, "We do all these things that are listed for the Wound Healing Tracking form, but I can't find any filled out for the residents with a pressure ulcer."

On 9/11/2019 at 1:31 PM, V16, Physician

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reported she would expect the facility to provide pressure relieving interventions for her residents who are a risk for skin breakdown. V16 stated, "Turning and repositioning every 2 hours, LAL mattress, nutritional assessment with interventions. For the feet, the same thing; relieving pressure points to the skin, feet, heels." V16 reported she was aware of the issue with R298's heel but could not remember which one. (B)

Licensure 2 of 2

300.610a)
300.1210b)5)
300.1210d)6)
300.3240a)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the 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

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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. Restorative measures shall include, at a minimum, the following procedures:
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 were not met as evidenced by:

Based on observation, interview and record review the facility failed to safely transfer 1 of 8 (R51) residents reviewed for accidents/hazards/falls in the sample of 52. This failure resulted in R51 requiring hospitalization at a local hospital for a fracture of the right upper leg.

Findings include:

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R51's Minimum Data Set (MDS) dated 11/07/2018 documented R51 is an extensive assistance of two plus staff person for transfers. And R51 is only able to stabilize with staff assistance when moving from seat to standing, moving on and off the toilet, and surface to surface transfer (transfer between bed and chair or wheelchair)

Per Illinois Department of Public Health, Serious Injury Incident Report, dated 12/11/18 at 06:00 AM, documents under Incident Category: Other; and next to "other" it is blank. In that same document, under Detail Incident Summary: "R1 was transferring with Certified Nurse Assistance (CNA) assist from bed to wheelchair. While transferring the CNA heard a pop. No pain upon assessment by the nurse. Observation of slight external rotation. In house x-ray ordered." It goes on to state in the final report of that document, "Resident has a history of a previous right hip fracture which occurred on 3/2013 and that this x-ray confirmed a fracture of the right distal shaft of the right femur. There is no documenting of another CNA assisting with this transfer.

R51's Progress Note, dated 12/11/18 at 6:22 AM documents, "CNA (certified nurse's assistant) reports that while transferring resident from bed to wheelchair CNA heard a "pop." Resident appears to have an indentation of femur above the knee and some external rotation of foot. Medical doctor made aware. Order received for X-ray. Doctor contacted and made aware. Director of Nurse (DON) sent message via text and cp voicemail." There is no documenting of another CNA assisting with this transfer.

Per 12/11/18 Written Hand Statement at 6:15 AM, V7 (CNA), documented, "On December 11, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003255	A. BUILDING _____ B. WING _____	09/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA SOUTHBELT HEALTHCARE	101 SOUTH BELT WEST BELLEVILLE, IL 62220

(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) COMPLETE DATE
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at about 6:15 am, I was preparing (R51) for breakfast. I changed her brief and I put on her bottoms. I went to try and transfer (R51) from the bed to the chair. In the process of me transferring (R51), her leg twisted and I hear a pop. I immediately put her in the chair to check and see if maybe the brief had unsnapped or ripped." Its further documents, "I tried to scoot her leg, it is looking weird to me. It was just dangling. I than hurried and told the nurse for that hall." There is no documenting of another CNA assisting with this transfer.

On 09/10/19 at 11:30 AM, V7 (CNA), stated that R51 can be combative with care. However, this time she wasn't and when she was transferring R51 from the bed to the wheelchair, she heard a "pop" so, she sat R51 back onto the bed and called for the nurse. V7 stated that V20, CNA assisted her with the transfer.

On 9/10/19 at 2:10 PM, call placed to V20. No answer. Left message on voicemail.

On 9/10/19 at 3:40 PM, V15, Licensed Practical Nurse (LPN) stated that she was not sure how many CNA's where in R51's room.

On 9/11/19 at 11:00 AM, V2 Director of Nurses (DON) stated that she would expect the staff, if ordered, to use 2 or more staff persons for assist with transfer. V2 also stated that they talked to V7 regarding V20 assisting her with R51, but somehow it didn't "add up."

R51's Progress Notes, dated 12/15/2018 at 05:57 PM documents "(A call) from local hospital sending resident back had surgical repair to right distal femur. Resident is toe touch weight bearing. Sutures intact, has follow-up date

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S9999	Continued From page 14 removal." in part. On 9/11/19 at 1:35 PM V16, Attending Physician, stated that she could not say if fracture was from, without looking at her supporting documents. She would have to look at her clinical records, in which she does not have access to at this time. The facility Gait Belt Use policy and procedure dated July/2014 documents, "Policy: It is the policy of Helia Heathcare that gait belts will be used when staff are transferring weight bearing residents or assisting them with walking for the safety of the resident or the employee. Procedure: #7 Request the assistance from a coworker if necessary" (B)	S9999		