STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003800	A. BUILDING: _____ B. WING _____	C 03/28/2018

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

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S 000	Initial Comments Complaint Investigation #1861755/IL101125 Statement of Licensure Violations	S 000		
S9999	Final Observations 300.1210b) 300.1210d)6) 300.3240a) 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. 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: 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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These requirements were not met as evidenced by:

Based on record review and interview the facility failed to ensure that a mechanical lift sling was safe for use prior to transfer for one of eighteen residents (R1) reviewed for mechanical lift transfers in the sample of 22. This failure resulted in R1 falling from the mechanical lift on two separate occasions, the second time sustaining a Subarachnoid Hemorrhage (brain bleed), and a Subdural Hemorrhage (brain bleed). R1 was subsequently hospitalized then transferred to another long term care facility where R1 expired. This failure had the potential to affect 17 additional residents (R5 - R7, R9 - R22) who shared the same supply of poorly maintained mechanical lift slings.

Findings include:

The Facility Face Sheet dated March 6, 2015 for R1 documents the following diagnoses: Obstructive Hydrocephalus (Primary, Admission), Cellulite of Left Lower Leg, Other Pulmonary Embolism, Chronic Kidney Disease Stage III, Morbid Obesity, Unspecified Dementia, Flaccid Hemiplegia Affecting Unspecified Side (History of Cerebrovascular Accident).

R1's Physician Order Sheet (POS) dated February 21, 2018 - March 21, 2018 documents the following medication order: Eliquis (blood thinner) five milligrams, by mouth, twice daily.

The Minimum Data Set (MDS) dated 12/24/17 documents R1 as being severely cognitively impaired and totally dependent on physical staff assistance for bed mobility. A discharge MDS

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S9999	Continued From page 2 dated 2/23/18 documents R1 was totally dependent for all transfers. R1's Care Plan dated 1/10/18 documents the following initiated problem of falls dated 6/24/15: "Resident has a history of falling related to Hemiparesis, balance issues, Dementia, diuretic use / other medications and Obstructive Hydrocephalus with shunt." The same care plan documents to "use a (mechanical lift) for all transfers." R1's "Resident Transfer Assessment" dated 11/29/17 documents the following:" (R1). Requiring more than 50 % assistance, is non-weight bearing, and transfers by (mechanical lift)." On 3/22/18 at 2:30 pm, Director of Nursing stated "All (mechanical lift transfers) are with two staff (assistance)." R1's Progress Notes dated 2/23/18 at 7:30 am, signed by V8, Licensed Practical Nurse (LPN) documents the following: "Called to (R1's) room by CNA (V4, Certified Nursing Assistant). Upon entering resident (R1) room, found resident on floor next to bed with head on pillow, wedged against night stand and lying on back. Resident noted with labored breathing and facial cyanosis. Large laceration noted on right side of head, above ear in half moon shape. Right eye swelling and bruising and swollen shut. Resident (R1) was able to open left eye in response to his name being called but not able to verbalize words. Pressure applied to head wound and bleeding stopped. 911 (Emergency phone number) called and EMT's (Emergency Medical Technicians) dispensed (dispatched) to nursing home (facility) and took over (R1's) care. (R1's) Power of	S9999		

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S9999	Continued From page 3 Attorney notified of incident. Resident (R1) taken to (Local) hospital by paramedics." R1's local hospital "Trauma Evaluation History and Physical" report dated 2/23/18 at 10:19 am document findings which include: "There is evidence of a Subarachnoid Hemorrhage (brain bleed) bilaterally, far worse on the right, involving the temporoparietal area on the right and the temporal region on the left. There is a small right parietal Subdural Hemorrhage (brain bleed) component." R1's "CT (X-Ray Image using Computerized Axial Tomography) Brain without Contrast" report dated 2/24/18 at 08:10 am documents the following: "Bilateral Subarachnoid Hemorrhage is again noted but appears to have increased. A definite small globular focus of extra - axial hemorrhage near the vertex measuring 11 millimeters has evolved from previous exam (2/23/18 at 8:20 am). There appears to be some minimal right to left midline shift of approximately three millimeters. No other acute changes." An Illinois Department of Public Health "Long Term Care Facility and IID - Serious Injury Incident Report" sent to the State Survey Agency dated 2/23/18 at 5:05 PM documents the following: "(R1) was being transferred via mechanical lift. (R1) sustained a fall with injury when the (mechanical lift) (cloth) sling sustained a tear." R1's "Resident Post - Fall Investigation - Form" dated 2/23/18 documents the following: "Resident (R1) being transferred by (mechanical lift) from bed to chair. Loop on (mechanical lift) sling tore allowing resident to slip out of sling onto the floor."	S9999		

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The facility fall investigation included a witness statement taken on 2/23/18 written and signed by V4, CNA that documents the following events taking place on 2/23/18 at 7:30 am: V4 stated "I had just put (mechanical lift) pad sling under resident (R1) to lift and put (R1) in chair. I didn't have help so I proceeded to lift (R1) up. (R1) was still over the bed when the sling broke and he (R1) went through the side and over (mechanical lift sling) to the ground."

On 3/20/18 at 10:38 am, V4, verified that R1 fell 2/23/18, from the mechanical lift sling, as V4 transferred R1 without the assistance of a second staff member. V4 stated V4 transferred R1 using the mechanical lift sling that had the top middle loop broken. V4 also stated V4 used the mechanical lift sling loop at the very top, above the broken middle loop. V4 stated that as V4 gave shift report on 2/23/18 at 2:00 pm to V7, V7 told V4 that V7 transferred R1 a few days earlier when the mechanical lift sling loop broke.

On 3/20/18 at 2:30 pm V7 stated the following: " Almost a week before (R1) fell (02/15/18) and went to the hospital (2/23/18), I was by myself operating the (mechanical lift). When I had (R1) over the bed, a sling loop snapped off because it was frayed. (R1) did not fall, I lowered (R1) the rest of the way down to the bed. I was uncomfortable with what happened. I went and showed (V10, CNA) the frayed top middle loop (of mechanical lift sling). We had a limited number of slings so I left the frayed sling (#3) in the (R1's) room. I thought the other two loops on the top (of mechanical lift sling) could be used. The sling was old, very much so. I went right away and told my supervisor (V11, CNA Supervisor), then went with (V11) to see (V3, Registered Nurse / MDS

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Coordinator). I reported to both (V3 and V11) that the sling strap broke during transferring (R1)." V7 also stated the following: " I feel bad for leaving the sling in (R1's) room, I know I shouldn't have."

R1's medical record contains no documentation of this first incident being investigated or any new interventions being put in place to safeguard R1 during mechanical lift transfers.

On 3/20/18 at 3:05 pm, R8, (R1's roommate) stated the following: "I was here (R8's room) twice when (R1) fell. The first time the fall was sudden and not far, just inches off the mattress when (R1) was dropped from the (mechanical lift). (R1) wasn't hurt. I think it scared the CNA (unidentified) more than anything. There was only one CNA both falls from the (mechanical lift). A week later (R1) fell, when the (mechanical lift) strap broke again. (R1) ended up hurt pretty bad."

The facility fall investigation included a statement taken on 2/23/18 written and signed by V7, CNA which documents the following previous knowledge V7 had of R1's mechanical lift sling (V7, worked second shift) : "I noticed one of the loops (mechanical lift sling) was broken, went to (V11, CNA Supervisor) to ask about ordering some new slings because the slings CNA's used was old and worn and we needed new (mechanical lift slings) and the proper sizes (for) residents. (V11) and I went to (V3, Registered Nurse / MDS / Care Plan Coordinator) and (V3) stated that they will be ordering some new ones (mechanical lift slings) soon, but they have to get approval."

On 3/20/18 at 3:35 pm V3 acknowledged that V3 had only ordered one mechanical lift sling on 2/20/18 "due to budget limitations for the month."

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V3 also stated "(V1, Administrator) ordered several more (mechanical lift slings) after (R1) fell (2/23/18) from the (mechanical lift)."

On 3/20/18 at 9:00 am V2, Director of Nursing submitted a list of residents (R5 - R7, and R9 - R22) that require full mechanical lift for transfers. On 3/21/18 at 9:45 am, V1, Administrator, submitted mechanical lift sling inspection tracking sheets for October 2017 - February 2018 that included sling numbers 1, 2, and 4 - 9. There is no documentation of sling numbered 3 (R1's sling) being inspected from October 2017 through February 2018. The February 2018 sling inspection tracking sheet documents that on 2/3/18 sling # 8 was inspected, and on 2/11/18 sling # 9 was inspected. There is no other documentation to indicate any other mechanical lift slings were inspected in February 2018, prior to R1's two falls 2/15/18 and 2/23/18.

On 3/21/18 at 11:00 am V1 (Administrator), acknowledged R1 fell from mechanical lift sling #3 and there is no documentation of sling #3 inspection October 2017 - February 22, 2018.

On 3/21/18 at 3:45 pm, V5, Laundry Supervisor acknowledged that V5 is responsible for the care and inspection of the mechanical lift slings and the mechanical lift slings do not always make it down to laundry to be washed and inspected for safety. V5 also stated "We automatically add bleach to the laundry detergent when there is bowel movement, urine or blood on the (mechanical lift) slings." V5 also stated "It's been over two years since the old (mechanical lift slings) were bought."

The "(Manufacturer's) Operational Manual" for mechanical care lifts dated 2008 documents the

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following on page 11: " Note: Never use bleach when laundering slings. Reject any sling or belt that has been laundered with bleach. It is the responsibility of the medical facility or user when operated in a home environment to monitor the condition of every sling or belt used." The same Operational Manual documents the following on page 20: " Every day: Inspect slings and belts for wear and tear before every use. Immediately remove any damaged slings and belts from service and replace."

An undated additional "(Manufacturer) Battery Operated Patient Lift (manual) "documents the following on page 8: " Never use a sling which is frayed or damaged." The same manual documents: "Do not lift a patient unless you are trained and competent to do so."

On 3/21/18 at 2: 25 pm V1, stated "My inservices (staff education) on (mechanical lift) transfers, I haven't found any, I went back through May 2016."

On 3/22/18 at 9:50 am, V12, Medical Director stated the following: "(R1's) Subarachnoid Hemorrhage and Subdural Hemorrhage were caused by the fall when the nurses transferred him (R1)."

On 3/20/18 at 10:15 am V1, Administrator verified that R1 transferred to another long term care facility after going to the hospital on 2/23/18 due to injuries sustained from the fall in this facility. V1 also stated "(R1) has since passed away (3/18/18)."

(AA)

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