Illinois Department of Public Health

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 03/06/2018

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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S 000	Initial Comments Facility Report Investigation to Incident of 2/7/18/IL100445 Statement of licensure violations	S 000		
S9999	Final Observations 300.610a) 300.1210b) 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 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/20/18

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S9999	Continued From page 1 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 These requirements were not met as evidenced by: Based on interview and record review the facility failed to transcribe an order for one to one (1:1) supervision with meals and failed to provide 1:1 supervision as ordered for one of three residents (R1) reviewed for aspiration precautions in a sample of three. This failure resulted in R1 with known swallowing deficits being left in his room to eat with no staff in attendance. R1 choked and was subsequently hospitalized where he expired. Findings include: R1's Physician Order Sheet dated 2/3/18 documents R1 was admitted to the facility on 2/3/18 with diagnoses of Tongue Cancer, Iron Deficiency Anemia, Hypertension, and Jaundice. R1's Baseline Care Plan dated 2/3/18 documents R1 was at risk for swallowing problems. R1's Admission Assessment- Oral Cavity	S9999		

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S9999	Continued From page 2 Observation dated 2/5/18 documents R1 had mouth dryness and difficulty moving his tongue and swallowing. R1's "Speech Therapy Plan of Care" dated 2/5/18 documents R1 was evaluated by V3 Speech Therapist on 2/5/18. The same Plan of Care documents R1 was referred to speech therapy for Poor Intake, Decreased Liver Function, Oropharyngeal Dysphagia (swallowing difficulty), and Active Tongue Cancer. The same Plan of Care documents R1 required Speech Therapy intervention, "to improve safe and adequate oral intake and cognitive function." The same Plan of Care documents an assessment which was suggestive of a moderate dysphagia (difficulty swallowing) and mild risk of aspiration. "Unilateral tongue resection (section was removed) was completed approximately a year ago. Patient has poor judgment with all activities of daily living and oral intake". R1's "Speech Therapy Progress and Discharge Summary" dated 2/15/18 (written after R1's death) documents R1 and V4 (R1's mother) were provided education regarding the need for 1:1 supervision for all intake. The same Summary documents, "education for staff regarding need for (R1) to come to dining room for all meals due to need for 1:1 supervision." R1's Physician's Telephone Order dated 2/6/18 documents V3 Speech Therapist ordered R1's diet to be changed from a regular consistency to mechanical soft with pureed meats, nectar thick liquids, and for R1 to have 1:1 Supervision. Facility Incident Report dated 2/7/18 documents R1 was eating dinner in his room with his mother (V4) present at approximately 5:00 PM. V4 came	S9999		

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to get a nurse and stated, "(R1) is not right". Staff (V9) Licensed Practical Nurse assessed R1 and found residual food in his mouth. The abdominal thrusts were performed and ambulance was called. R1 had labored breathing and a pulse when leaving the facility. R1's mother (V4) notified the facility that R1 passed away the next day.

On 2/22/18 at 4:15 PM V9 LPN stated she was called to the room by R1's mother at approximately 5:00 PM. V9 stated she found R1 in his bed unresponsive and not breathing. Emergency Medical Services (EMS) were called. V9 stated she did a finger sweep and retrieved a few small particles of pickled beets. V9 stated abdominal thrusts were performed with no results. V9 stated as she moved R1 onto his left side he took a gasping breath and began to breath irregularly. An oxygen mask was applied and R1 continued the irregular breathing until the ambulance arrived and EMS took over. V9 stated she was never informed that R1 was supposed to have 1:1 supervision while eating.

Ambulance Run Report dated 02/07/18 documents that the service received a call from the facility at 4:59 PM and upon arrival patient was found jaundiced and sitting in bed with a pulse of 48 and shallow respirations. Patient transported to hospital.

On 2/22/18 at 11:00 AM V7 Care Plan Nurse stated R1 was on swallowing precautions due to his tongue cancer and he needed observation during meals. At 1:00 PM V7 confirmed that the need for 1:1 supervision with meals was not on R1's Care Plan.

On 2/22/18 at 3:21 PM V3 Speech Therapist

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stated during her evaluation of R1 on 2/5/18, he was pocketing a lot of food in his left cheek and because of the lack of sensation due to his tongue resection, she felt R1 needed cueing and supervision while eating. V3 stated she wrote an order for a change in R1's diet and for R1 to have 1:1 supervision while eating.

On 2/23/18 at 12:37 PM V5 LPN stated she did receive the telephone order for R1's diet change and 1:1 supervision from V3 Speech Therapist however when she entered it into the EMR (Electronic Medical Record) system, she must have missed the order that R1 required 1:1 supervision. V5 confirmed that the order for 1:1 supervision was missing from R1's EMR.

On 2/28/18 at 10:21 AM V1 Administrator stated he acknowledges that V5 LPN failed to transcribe V3's order for 1:1 supervision.

On 2/23/18 at 2:45 PM V3 Speech Therapist stated R1 was on a regular diet when he entered the facility. V3 felt this was not safe for him. V3 stated on 2/5/18 she spoke with V2 Nurse Practitioner about the need for R1 to be supervised while eating. V3 also states she spoke with R1 and his mother (V4) about the need to be supervised while eating. V3 stated R1 needed cueing to swallow twice and not pocket food while eating. V3 stated she told V8 Certified Nursing Assistant that R1 needed to be supervised when eating. V3 stated on 2/6/18 she wrote a telephone order for a diet change and 1:1 supervision for R1 and then handed and explained the order to V5 Licensed Practical Nurse. V3 stated her expectation is that the 1:1 supervision order be followed by staff and feels if it would have been, R1 might not have choked or might have had a different outcome.

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On 2/23/18 at 1:15 PM V8 CNA stated he was never told by anyone that R1 needed to have 1:1 supervision while eating and normally that information would have been passed on in shift change report.

On 2/23/18 at 9:12 AM V10 Certified Nurses Assistant stated she took care of R1 on 2/7/18. V10 stated she was not told that R1 was supposed to have 1:1 supervision while eating. V10 verified that information like this is passed on during shift report.

On 2/28/18 at 8:45 AM V4 R1's Mother stated she was never educated by any facility staff about R1 requiring 1:1 supervision while eating. V4 stated she was never told that if she left the room she should call staff or take R1's food tray out of his reach. V4 stated that if she had been educated regarding her son (R1) needing 1:1 supervision while eating, that she would not have felt comfortable being responsible for that supervision because she was, "(R1's) mother not trained personnel." V4 stated she, "did not know what to do when R1 started choking and (she) felt helpless." V4 stated she, "did not know how to help (R1)." V4 stated that staff had never supervised R1 while he was eating and his door was often closed even when he ate his meals.

On 2/28/18 at 11:05 AM V2 Nurse Practitioner stated that she agreed that R1 did not receive the safest care when at the facility because the order for 1:1 supervision while eating was not followed and R1 ended up choking.

R1's hospital History and Physical Note dated 2/7/18 documents R1 had a, "choking episode resulting in cardiac arrest, status post CPR

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S9999	Continued From page 6 (cardio-pulmonary resuscitation) and intubation". The same H&P documents R1 experienced, "Acute Respiratory Failure secondary to aspiration of food" and was left in a, "Coma from anoxia." R1's Medical Discharge Summary dated 2/8/18 documents R1 was extubated and expired on 2/8/18 at 4:07 PM. (A)	S9999		