Illinois Department of Public Health

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Complaint 2142228/IL132375	4	S 000			
					3 .
S9999 Final Observations					
		S9999			
Statement of Licensure Violation:					12
300.610a)		101			
300.1210 b) 300.1220 b)2) 300.3240 a)					
Section 300.610 Resident Care Police	cies				
a) The facility shall have written procedures governing all services profacility. The written policies and procedure formulated by a Resident Care Policies consisting of at least the administrator, the advisory physician medical advisory committee, and report of nursing and other services in the familiary policies shall comply with the Act and The written policies shall be followed the facility and shall be reviewed at least the policies committee, documented by we and dated minutes of the meeting.	ovided by the sedures shall blicy or the presentatives acility. The state of this Part. In operating east annually				
Section 300.1210 General Requirem Nursing and Personal Care	nents for				
b) The facility shall provide the r care and services to attain or maintai practicable physical, mental, and psy well-being of the resident, in accorda each resident's comprehensive resid plan. Adequate and properly supervis care and personal care shall be prov	in the highest rchological ince with lent care sed nursing		Attachment A Statement of Licensure Violations		

STATE FORM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Illinois Department of Public Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ C B. WING 04/22/2021 IL6006704 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **40 NORTH 64TH STREET** HELIA HEALTHCARE OF BELLEVILLE **BELLEVILLE, IL 62223** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 1 resident to meet the total nursing and personal care needs of the resident. Section 300.1220 Supervision of Nursing Services The DON shall supervise and oversee the nursing services of the facility, including: Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 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 are not met as evidenced by: Based on observation, interview and record review, the facility failed to answer call lights in a timely manner for 5 of 5 residents (R1, R2, R3, R4, R5) reviewed for resident rights in the sample of 16. This failure resulted in R1 experiencing extreme anxiety and fear that she would not receive assistance if she had a mucous plug obstructing her tracheostomy which would cause death because call light is not answered timely. Findings include: 1. R1's Minimum Data Set (MDS), dated

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3/19/2021, documents R1 is cognitively intact, is on a ventilator or respirator, requires extensive

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		IL6006704	B. WING			C 04/22/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, 8	STATE, ZIP CODE			
HELIA HI	EALTHCARE OF BEL	I FVII I F	'H 64TH STRI LLE, IL 6222				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF (CORRECTION	(X5)	
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO			COMPLETE	
S9999	Continued From pa	ge 2	S9999				
	hygiene, is totally d	d mobility and personal ependent for bathing, always all and bladder, and does not					
23	R1's Physician orders, dated 3/12/2021, document to perform tracheostomy care twice daily.						
1 1	medical diagnoses failure, unspecified hypercapnia. Interv in reach at all times R1's care plan for v 03/12/2021, docum	entilator/respirator, dated ents the goal to ut complications. Interventions					
	They do not answer in on me. When the hateful and I have to DON), but she does on me. I was a nurs a plug and I am afrasomeone and see it done? I have talked busy, but I really wo am so afraid." R1 a issue since she was talked to the DON resolution. 2. On 4/9/2021, R3	B AM, R1 stated, "I am afraid. In the call lights at night or look by do come, they are very cold V2 (Director of Nurses, son't always have time to look in the eard I know that I could have aid. Will you please talk to f you can get something d to (V2) and I know she is could like you to do something I liso stated this has been an the admitted 3/12/2021 and has consultiple times about it with no					
	minutes later. R3's MDS, dated 2/	1/2021, documents, R3 is on a ventilator or respirator,					

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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		IL6006704	B. WING			22/2021	
NAME OF	PROVIDER OR SUPPLIER		-	STATE, ZIP CODE			
HELIAH	EALTHCARE OF BEL	EVILLE	H 64TH STR LLE, IL 622			,	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From page 3		S9999				
	extensive assist of o totally dependent fo	assist of 2 for bed mobility, one for personal hygiene, is r bathing, has a urinary nally incontinent of bowel, and					
	R3's Care plan, dated 3/3/2021, documents the interventions to include remind resident to call for assistance as needed.						
	3. On 4/9/2021, R4 AM and it was not a minutes later.	turned on the call light at 9:50 nswered until 10:13 AM, 23					
	moderate cognitive or respirator, require bed mobility, extens hygiene, is totally de urinary catheter, is a	19/2021, documents, R3 has impairment, is on a ventilator es extensive assist of 2 for ive assist of one for personal ependent for bathing, has a always incontinent of bowel, oth upper extremities, and	j sjet est				
	R4's Care Plan, date interventions to inclual times.	ed 3/15/2021, documents ude keep call light in reach at					
	stated, "They do not facility for my brothe that he had his call li would call the facility call light. They did no	00 PM, V8, R2's sister, answer the call lights at the r. He would call me and say ight on for an hour and I v and tell them to answer his ot check on him like they check on him when he went					
	cognitively intact, is crequires extensive a	9/2021, documents, R2 is on a ventilator or respirator, ssist of 2 for bed mobility, personal hygiene and					

FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING IL6006704 04/22/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **40 NORTH 64TH STREET** HELIA HEALTHCARE OF BELLEVILLE **BELLEVILLE, IL 62223** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 4 bathing, is always incontinent of bowel and bladder, and does not walk. 5. On 4/9/2021 at 9:25 AM, V3, Respiratory Care, stated that the residents who are interviewable will tell you if the call lights are answered in a timely manner. V3 was standing outside in the hall when R5 was asked if the call light was answered timely. R5 replied, "No, they are not." V3 then stated, "You see what I mean?" R5's MDS, dated 1/5/2021, documents, R5 is cognitively intact, is on a ventilator or respirator, requires extensive assist of 1 for bed mobility and personal hygiene, is occasionally incontinent of bowel and bladder, has impairment of both upper extremities, and does not walk. R5's Care Plan, dated 7/3/2020, documents interventions to include keep call light in reach at all times. On 4/9/2021 at 10:45 AM, V2, DON, stated, "I expected the call light to be answered by the closest person to the room within minutes." V2 also stated that it is unacceptable for someone to wait 15 minutes for a call light to be answered. The Resident Grievance log for February 2021 documents complaints of call lights not being answered. The facility's Answering the Call Light policy and procedure, dated 7/2014, documents, "The purpose of this procedure is to respond to the resdietn's requests and needs." It continues under General Guidelines, "8. Answer the resident's call as soon as possible."

Illinois Department of Public Health

(B)

PRINTED: 06/08/2021

FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING IL6006704 04/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 NORTH 64TH STREET** HELIA HEALTHCARE OF BELLEVILLE **BELLEVILLE, IL 62223** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

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