PRINTED: 09/28/2022 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WING IL6006704 07/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 NORTH 64TH STREET** HELIA HEALTHCARE OF BELLEVILLE **BELLEVILLE, IL 62223** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG DEFICIENCY) S 000 S 000 **Initial Comments** Conditional Licensure Follow-up to survey date 12/15/21, Complaint #2148670/IL149536. Annual Licensure S9999! Final Observations S9999 Final Observations

The facility shall have written policies and a) 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.

Statement of Licensure Violations:

Section 300.610 Resident Care Policies

1 of 3

300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)3)6) 300.1220b)3) 300.3240a)

> Affachment A Statement of Licensure Violations

inois Department of Public Health ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Section 300,1010 Medical Care Policies

TITLE

(X6) DATE

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6006704 07/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 NORTH 64TH STREET** HELIAHEALTHCARE OF BELLEVILLE **BELLEVILLE, IL 62223** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE **TAG** TAG DEFICIENCY) S9999 Continued From page 1 S9999 The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's quardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		i ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	resident to meet the care needs of the re	e total nursing and personal esident.				
	nursing care shall in	subsection (a), general nclude, at a minimum, the peracticed on a 24-hour, pasis:				
	resident's condition emotional changes, determining care re further medical eval	oservations of changes in a , including mental and as a means for analyzing and quired and the need for luation and treatment shall be aff and recorded in the ecord.				
	to assure that the re as free of accident in nursing personnels	ry precautions shall be taken esidents' environment remains nazards as possible. All thall evaluate residents to see eceives adequate supervision revent accidents.				
(*)	Section 300.1220 Services	Supervision of Nursing				
		nall supervise and oversee the the facility, including:		n <sub>e</sub> .	:	
	plan for each reside comprehensive ass and goals to be acc and personal care a Personnel, represer nursing, activities, d modalities as are or be involved in the pi plan. The plan shal	an up-to-date resident care int based on the resident's essment, individual needs omplished, physician's orders, and nursing needs. In the services such as ietary, and such other dered by the physician, shall reparation of the resident care I be in writing and shall be ied in keeping with the care				

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING IL6006704 07/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 NORTH 64TH STREET** HELIAHEALTHCARE OF BELLEVILLE **BELLEVILLE, IL 62223** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 3 S9999 needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Requirments were NOT MET as evidence Based on interview and record review, the facility failed to change a tracheostomy tube as ordered in 1 of 4 residents (R23) reviewed for tracheostomy care in the sample of 28. Findings include: On 7/19/22 at 10:30AM, R23 stated that her tracheostomy tube has not been changed since around February 2022 and it's "hurting." R23 states they have not changed it because they don't have the right size. R23 was observed with a size 6 tracheostomy in place, undated. R23 was being provided ventilator support for breathing. R23's Physician Order Sheet (POS), documents an order dated 6/18/22 to change the tracheostomy tube every 2 months, once between the 1st and 15th of January, March, May, July, September and November. R23's Minimum Data Set (MDS), dated 6/10/22. documents R23 is cognitively intact and is receiving tracheostomy care, ventilator support. suctioning and oxygen therapy.

R23's Care Plan, dated 1/5/21, documents R23

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	potential for complic tracheostomy status	r/respirator and has the cations related to s.					
		Iministration Records, me R23's tracheostomy was					
	changed was 1/24/2	22. There is no documentation					
	in the treatment rec	ords that R23's tracheostomy n February 2022, March 2022,					
1.5	April 2022, May 202	2, June 2022 or July 1st					
	through July 21st. T	he tracheostomy tube was 23/22 after being brought to					
	the attention of the I	Director of Nurses on 7/22/22.					
de		es document the following:					
	Progress notes: 7/23	3/22 at 12:44AM, changed, resident tolerated		·			
	well.	mangou, rosidori tolorated					
		PM, V22 Respiratory					
		ed they do have R23's in stock. V22 stated, he					
6	looked through their	documentation and there is	l				
	no documentation th	nat R23's tracheostomy tube I 2022, May 2022, June 2022					
1	or July 1st through J	uly 21st, 2022. V22 stated					
	the RTs change the document when they	tracheostomy tubes and					
ļ		_					
		M, V13, RT, stated if the snot changed as ordered the				1 1	
		start to attach itself to the					
	tube.						
		PM, V23, Nurse Practitioner,					
		stomy tubes are not changed use an increased risk of					
	respiratory infections					,	
	On 7/22/22 at 8:35Al	M, V2, Director of Nurses					

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but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6006704 07/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 NORTH 64TH STREET** HELIAHEALTHCARE OF BELLEVILLE **BELLEVILLE, IL 62223 SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **TAG** DEFICIENCY) S9999 Continued From page 6 S9999 of notification. Section 300.1210 General Requirements for Nursing and Personal Care The facility shall provide the necessary Ы 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: C) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: All treatments and procedures shall be 2) administered as ordered by the physician. 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. Based on observation, interview and record

review, the facility failed to turn and reposition, implement pressure relieving devices, and

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left outer great toe and left great toe (which had black edges) as deep tissue injuries. R21's right

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foot, Pressure ulcer of sacral region, stage 4.

R21's Initial Wound Evaluation and Management

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION  3:		3) DATE SURVEY COMPLETED			
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S9999	Continued From pa	ge 9	S9999						
i	as: an unstageable right heel that meas (by) 5 centimeters x	23/22 identifies her wounds deep tissue injury (dti) of the sures 3 centimeters (cm) x a not measurable;							
	5cm x 5 cm x not m the right ear measu measurable; unstag measuring 0.5 cm x	he left heel that measures leasurable; unstageable dti of ring 0.5cm x 0.5cm x not leable dti of the right elbow to 0.5 cm x not measurable; ound of sacrum measuring 6				772			
	R21's Physician Ord	der dated 5/24/22 documents: eep tissue injuries to left heel		¥ <sub>2</sub>		明 一			
V.	Summary Reports of documents additions. Shear wound of left x not measurable; 6 elbow measuring 2 of 7/12/22 stage 4 preselbow measuring 1 of wound of right upper cm x not measurable hip measuring 2 cm and on 7/18/22 there identified as a shear measuring 5 cm x 3 shear wound to right x not measurable (the shear wound to right x not measurable).	ation and Management lated 5/30/22 to 7/18/22 al pressure injuries as: 6/6/22 face measuring 1 cm x 1 cm /20/22 Unstageable dti of left cm x 2 cm x not measurable; ssure ulcer of left lateral cm x 1 cm x 0.4 cm, shear r back measuring 2 cm x 1 e, and shear wound of left x 1 cm x not measurable; were two additional wounds wound to right lower back cm x not measurable and a thip measuring 3 cm x 4 cm he dti to left medial elbow and tupper back were resolved		(注) (注)	(0				
inois Depart	documents she refus non-sensical answer Interview for Mental	a Set (MDS) dated 6/1/22 sed to answer or gave is to questions for Brief Status so unable to status. It documents she		_					

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documentation of the unstageable pressure ulcer

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On 7/27/22 at 9:20 AM V2 stated, "I have not documented or measured any of the new wounds

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 07/27/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **40 NORTH 64TH STREET** HELIAHEALTHCARE OF BELLEVILLE **BELLEVILLE, IL 62223** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 Continued From page 13 S9999 we found on 7/21/22. I have not got around to it. I thought you were doing it because you were writing down all the new areas we found. Typically, I would address a new wound as soon as I find out about it. I would go and assess it. measure it and notify the wound doctor to get orders." 2. On 7/19/22 at 9:30AM, 10:00AM, 10:30AM, 11:30AM, 12:30PM and 1:30PM R18 was positioned on her back, heel lying on the bed and not off loaded off of the mattress. There was no pressure relieving boot on R18's right foot, and there were no pillows for positioning. On 7/20/22, at 3:10PM, R18's foot continues to have no boot, heel lying on the bed and not off loaded off the mattress, and there were no pillows for positioning/pressure relief. R18's Face Sheet undated, documents R18 has the following diagnoses: Severe Calorie Malnutrition, Pressure Ulcer of Sacrum Region, Quadriplegia, bed confinement status, Pressure Ulcer to right upper back. R18's MDS dated, 5/24/2022, documents R18 is dependent on staff for bed mobility, has pressure ulcers, and has the following interventions in place pressure relieving devices receives pressure ulcer care, and on a turning and repositioning program. R18's Care Plan dated, 8/15/19 documents R18 is at Risk for Pressure Ulcers with interventions for a pressure relieving boot, to elevate heel off of bed, and turn and reposition every two hours. R18's Physician Order Sheet documents, order dated, 4/13/22 to off load heels while in bed.

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING IL6006704 07/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 40 NORTH 64TH STREET HELIAHEALTHCARE OF BELLEVILLE **BELLEVILLE, IL 62223** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 14 S9999 R18's Wound Evaluation Summary dated, 7/18/22, documents R18 has the following pressure area's: Stage 4 Pressure Wound Sacrum wound size 4 cm x 7cm x 0.6 cm; Shear wound of the left lower buttock, wound size 4.5cm x 5 cm x 0.5 cm; Stage 4 Pressure Wound of the right, lateral upper back, wound size 3.5cm x 2.5cm x 0.4 cm; Shear Wound of the Right, Proximal, Plantar foot, wound size 2cm x 1cm x 0.2 cm; Shear Wound of the Right, Lateral Foot Full Thickness, wound size 2cm x 2cm x 0.3 cm. On. 7/19/22 at 1:50 PM, V11, CNA, stated, R18 gets turned every two hours and is dependent on staff and takes two staff to assist in turning and repositioning. V11, stated, "We try and get help from other CNA on another floor, or the nurse, but that does not happen most of the time". On, 7/21/22, at 9:00 AM, V16, (LPN), stated, "We need more (CNAs), for quality of care to be done. we have a lot of dependent residents down these halls, most residents take two staff for assistance for turning and repositioning, and other care." On 07/22/2022 at 2:25PM, V2, Director of Nursing (DON), stated, she would expect a resident that is dependent with care and has pressure ulcers to be turned and reposition every two hours. V2 stated, she would expect residents that had pressure relieving devices ordered for staff to use the devices, and stated, "yes", the devices should be used (boots, pillows, offloading from bed)." The facility's policy, "Wound Management Program " dated 02/26/2021, documents," It is the policy of (facility) to manage resident skin integrity through prevention, assessment, and implementation and evaluation of interventions, 5.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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33333	The facility will assecurrent skin condition identified, write a number of the protocol or Nether and the protocol or Nether area will be a sessment and the protocol or Nether patient will be "Clinically Unavoida Assessment Tool. To the attending phynurse will measure obtain appropriate to guardian/family mer document the area of Administration Recomments, Interventuring/repositioning continuous consister resident's position approgram us defined	ess residents weekly for ons. c. If any new areas are preserved in the area col followed to treat it, Skin we Skin Condition Protocol. d. e noted on the 24-hour report. e assessed using the ble Pressure Sore Guidelines this tool will then be reviewed vician for verification. f. The the area; call physician to reatment order, call the mber to inform him/her, on the TAR (Treatment ord) and initiate treatment."  sident dated, 5/2/22, antions/Care Strategies, "A grogram includes a nt program for changing the nd realigning the body. A as a specific approach that is documented, monitored, and	29999			6.00
	3 of 3		-00	e <del>l</del>		**)
<b>ં</b>	300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)2)4)A) 300.3240a)	22	* :			Q#E
2.3	Section 300.610 Re	sident Care Policies				

a) The facility shall have written policies and procedures governing all services provided by the

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following procedures:

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

Each direct care-giving staff shall review

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		and be knowledgear respective resident d)  Pursuant to nursing care shall in following and shall be seven-day-a-week be 2)  All treatment administered as ord 4)  Personal care 24-hour, seven-day-include, but not be limpersonal attention, in oral hygiene, in additional hygiene, in the residents (R5, R7, R9, enteral feedings in the resulted in facility not R9's significant weight delay of treatment for tube.  Findings include:  1. On 7/19/22 at 12:5	ble about his or her residents' care plan. subsection (a), general clude, at a minimum, the procedures shall be procedures shall be ered by the physician. The shall be provided on a a-week basis. This shall mited to, the following:  In shall have proper daily including skin, nails, hair, and the to treatment ordered by the physician of the following shall have proper daily including skin, nails, hair, and the total treatment ordered by the see, administrator, for a facility shall not abuse or section 2-107 of the Act)	35555			
	- 40	concerns with R9's ca	are in the facility. V18 stated on Father's Day, June 14,				

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x 23hrs (increased 5/4) to provide:

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**40 NORTH 64TH STREET** 

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	1518kcal(calories), 76gP(protein), 1032ml, 2182ml total fluids. no intol (intolerance) reported. skin intact. has L (left) hemiplegia, +2 pitting edema L foot. monitor potential weight fluctuations. CBW (current body weight) 5/4 183.4 lbs. (pounds). appropriate to increased TF as effort to meet ENN (estimated nutritional needs). 5/4 has x1 dose potassium d/t (due to) labs. conts (continues) Abt (antibiotic) until 5/14. monitor need to change TF if po (by mouth) diet advances. recommend: 1. change TF to Diabetisource at 70ml/hr x 23hrs to provide: 1932kcal, 97gP, 1313ml fluid, 2463ml total fluid. cont flushes as ordered. adjust TF as needed pending labs, skin, wt (weight), tolerance. will follow.			The second secon
	R9's Progress Notes dated 6/22/2022 at 2:05 PM documents "RD NOTE: CBW 6/17 157 lbs. stable to 6/2 158.6 lbs. but overall loss 5/4 183.4 lbs, questioned 5/18 288 lbs. BMI=23. remains on regular liquids as desired, no solids and TF/flushes for total nutrition/hydration. Conts (continues) Diabetisource AC at 70ml/hr x 23hrs, flushes 50ml/hr x 23hrs. reported with chronic loose BM (bowel movements) now but remains with Abt/Cdiff. question potential formulary intol as well. may benefit from formula with insoluble fiber as effort to support bowel function. current ENN: 1775-1988kcai (25-28kcal/kg BW), 71-85gP (1-1.2gP/kg BW), 1775-2130ml (25-30ml/kg BW). recommend: 1. consider changing TF formula to Isosource 1.5 at 55ml/hr x 23hrs to provide: 1897kcai, 86gP, 966ml fluid, 2116ml total fluid. cont flushes 50ml/hr x 23hrs. monitor wts as available and TF tol. will follow. (This documentation indicates a weight loss of 24. 8 pounds from 5/4/22 to 6/2/22 (1 month) which is a 13.5 % weight loss in just one month.)"			30*

**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: B. WING IL6006704 07/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 NORTH 64TH STREET** HELIAHEALTHCARE OF BELLEVILLE **BELLEVILLE, IL 62223 SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) S9999 Continued From page 20 S9999 There was no documentation that the recommendations of the Registered Dietician were implemented after assessment on 6/22/22. R9's Progress Note dated 6/23/2022 at 1:30 AM documents, "at 10 am this nurse notified by cna (Certified Nursing Assistant) that resident not responding normally, upon eval resident began responding some, b/p 65/42., 200 cc water flush given, rechecked b/p at 1010 am 62/40, call placed to on call NP (Nurse Practitioner), N/O (New/order) midodrine 10 mg pt PRN (as needed) QID (4 times a day), midodrine given as ordered, rechecked b/p at 1050am 84/64. resident responding normally at this time, no c/o (complaint of) pain or discomfort noted. rechecked b/p at 1150 76/50, continues to respond appropriately, another 200 cc water flush given along with midodrine. rechecked b/p at 130pm 90/54, resident continues to respond appropriately, no c/o noted. HOB elevated. resident continues on isolation for c-diff, loose stool continue, looks like tube feeding. incontinence care provided and tolerated well, call light within reach will continue to monitor." Progress Note dated 6/28/2022 at 11:57 AM documents, "seen by NP, clay colored BM noted at time. n/o KUB and abdominal ultrasound. call placed to (contracted radiologist) for KUB and Abdominal ultrasound, order and face sheet faxed to for (contracted radiologist) ultrasound." R9's Progress Note dated 6/28/2022 at 3:29 PM documents, "n/o change tf to Isosource 1.5 at 55cc hr with water flush 50 cc hr and labs in am.

6/22/22).

lab reg filled out and placed in lab box. (This change in TF was recommended by the RD on

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Requesting to hold off on surgical consult for g tube placement. States that surgeon had concerns about g tube placement surgery, that resident isn't stable enough. Requesting "something between pureed and mech. soft." States that resident has lost weight recently. Will

prevention with eating and recent g tube removal.

consult NP and dietician for weight loss

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timely weights for R9 from his admission, and

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**40 NORTH 64TH STREET** 

HELIA HEALTHCARE OF BELLEVILLE  40 NORTH 64TH STREET  BELLEVILLE, IL 62223							
(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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	then weekly thereafter because he had a g-tube, they may have recognized there was a problem with his g-tube sooner by investigating his rapid weight loss.  2. R12's POS dated July 2022 document R12 is on Fibersource tube feeding High nitrogen at 65 cc (Cubic centimeter per second) x 23 hours and continuous H20 (water) at 40 cc per hour x 23 hours.						
X	R12's Care Plan dated 5/26/2022 documents Problem: "Resident has NPO (nothing by mouth) status all nutrition and fluids per g-tube."	96	F				
	On 7/22/22 at 1:24 PM, R12's tube feeding machine was running with the number 55 displayed on it with 100 mL flush. (This was not what was ordered on the POS).	  					
	On 7/22/2022 at 1:25 PM, V13, Respiratory Therapist stated, "I am not sure what (R12's) tube feeding should be running at. Right now, R12 is running at 55 cc right now."		n <b>2</b> 7				
# 1	On 7/22/2022 at 10:29 AM, V2, Director of Nursing stated, "I would expect physician orders to always be followed. I was not aware (R12's) tube feeding was not running correctly."  3. On 7/20/22 at 9:00 AM, R5 was receiving Isosource (tube feeding) 1.5 calorie tube feeding at 55 milliliter (ml) per hour. The tube feeding bag had 800 ml (milliliters) left (full bag contains 1000 ml) in the bag and the bag was dated as being hung on 7/20/22 at 3:00 AM. At this rate and the documentation on the bag of being hung as documented, there should have been approximately 670ml left in the bag.						
	On 7/20/22 at 1:25 PM, 1:40 PM, 1:50 PM, 1:55 PM, 2:00 PM and 2:15 PM, R5 was not hooked						

**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: \_ IL6006704 07/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **40 NORTH 64TH STREET** HELIAHEALTHCARE OF BELLEVILLE **BELLEVILLE, IL 62223** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S9999 S9999 Continued From page 25 up to the tube feeding. R5's Face Sheet, undated, documents R5 has a diagnosis of Gastrostomy. R5's Physician Order Sheet (POS) documents the following orders: 4/7/22 - Enteral Feeding: Isosource 1.5cal at 55 cubic centimeters (cc) per hour, continuous for 23 hours; 5/27/21 - Weekly weight. R5's Minimum Data Set (MDS), dated 4/28/22, documents R5 receives 51% or more of his nutrition through enteral means. R5's Care Plan, dated 1/5/21, documents R5 is at risk for complications related to gastrostomy tube site and to provide enteral feedings as ordered. R5's care plan does not document R5's weight loss. R5's record documents the following weights: 7/08/2022 164.2 pounds (lbs.); 6/23/2022 162.2 lbs.; 6/17/2022 183 lbs.; 6/01/2022 175 lbs.; 5/20/2022 169 lbs.; 5/04/2022 172 lbs.; 4/20/2022 173.6 lbs.; 3/08/2022 187.4 lbs.; 2/18/2022 181.1 lbs.; 1/07/2022 187 lbs. The weights show a significant weight loss of 6.29%, 5.53% in 3 months and 12.3% in 6 months. R5's weight was not taken weekly as ordered by the physician. R5's Progress Notes written by V19, Dietician, document the following: 6/22/2022 at 5:22PM CBW 6/17 183lbs stable x 3 months; 3/8/22 187.4lbs but noted variance from previous loss 5/4/22 172lbs, 6/1/22 175lbs. Monitor as available for possible fluctuations. BMI=28.6, remains

Nothing per Os (NPO). Continues Isosource 1.5 at 55ml per hour for 23 hours and flushes 50ml per hour for 23 hours. This provides: 1897kcal,

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ IL6006704 B. WING 07/27/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 40 NORTH 64TH STREET HELIAHEALTHCARE OF BELLEVILLE **BELLEVILLE, IL 62223 SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 26 S9999 86gP, 966ml fluid, 2116ml total fluid. No tube feeding intolerance reported. Skin intact, no new labs, medication changes. Speech therapy discontinued this date. Monitor weights, tube feeding tolerance and skin status. Continue planof care; 7/20/2022 at 2:23PM CBW 7/8 164.2 lbs. indicates undesirable weight loss to available history. Remains NPO. Failed repeat modified barium swallow study in April. Tube feeding/flushes providing total nutrition/hydration. Continues Isosource 1.5 at 55ml per hour for 23 hours, flushes at 50ml per hour for 23 hours to provide: 1897kcal, 86gP, 966ml, and 2116ml total fluids. This meets lower estimated needs. No intolerance reported. May benefit from slight tube feeding increase as effort to meet high end estimated needs. Skin intact. No current labs. Monitor tube feeding tolerance with increase rate recommended: 1. change TF to Isosource 1.5 at 60ml per hour for 23 hours to provide: 2070kcal, 94gP, 1054ml fluid, 2204ml total fluid as effort to stabilize. Monitor weights as available. On 7/21/22 at 2:05PM, V19, Dietician, stated R5's weight loss could be due to progression of his disease. V19 stated R5's tube feeding was at the lower end of providing his caloric needs so she recommended to increase the rate to increase his caloric needs and hopefully this will stabilize him. V19 stated they attempted a modified barium swallow study on R5 but he failed. V19 stated the facility has not brought any concerns to her attention about the tube feeding or going long periods of time without it. 4. On 7/19/22 at 2:14 PM, R7 was receiving Novosource tube feeding at 40ml per hour.

On 7/20/22 at 1:30 PM R7's tube feeding pump was beeping flow error. The tube feeding

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month and 22.4% from 5/1/22 through 7/8/22.

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available. Skin with wound behind right ear. Wears brace to the left leg. No labs current. Current body weight on 4/3022 at 14lbs. Receiving prosource for additional protein as effort to exceed protein needs. Will advise to

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY	
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	Recommend: 1. che for 23 hours for a to tube feeding tolerar Adjust tube feeding					
	R7's weight loss is a weighed without he been weighed prior stated (V19) increas 7/20/22 and the rec stated R7's tube fee but she increased hot brought any cor	AM, V19 stated the reason for unclear if it was due to being a brace and she had possibly to with her brace on. V19 sed R7's tube feeding rate on commendation is pending. V19 ading rate exceeds her needs er rate. V119 stated staff have been off for long periods of				W SE
	"At our last Quality about weight varian because I am new, were taking weight? taking the weights fit decided moving for weigh residents so this way we know weight weight weekly for they are to be weight weights are discuss and dietician and the made. V2 stated if a is a significant change weekly weights or return the "Weight Manage".	PM. V1, Administrator, stated, Assurance Meeting we talked ces. When we get referrals I was curious about how we Later, I found out they were rom the hospital weights. We ward, to ensure we ourselves we develop our own baseline. What their real weight truly is."  AM, V2, Director of Nursing, dmission a resident is 4 weeks, if on tube feeding, and weekly. V2 stated then the led with the nurse practitioner en recommendations are a weight is inaccurate or there ge they will continue with eweigh.  ement Program" policy, dated the following: "2. On the first				

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