STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
"REPEAT B" VIOLATION(S)
STATEMENT OF VIOLATIONS

HELIA SOUTHBELT HEALTHCARE	0048587
Facility Name	I.D. Number
101 SOUTH BELT WEST, BELLEVILLE, ILLINOIS 62220	
Address, City, State, Zip	
02441, 18196	MAY 21, 2009
Reviewed By	Date of Survey
SECOND PROBATIONARY LICENSURE	02434, 02567, 02597, 05399, 13106, 21000
Type of Survey	Surveyed By

As a result of a survey conducted by representative(s) of the department, it has been determined the following violations occurred. Please respond to each violation. The response must include specific actions which have been or will be taken to correct each violation. The date of which each violation will be corrected must also be provided. Forms are to be submitted with the original signature.

IMPORTANT NOTICE: THE STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 83-1530. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THE FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

"REPEAT B" VIOLATION(S):

300.1210a)
300.1210b)5)

Section 300.1210 General Requirements for Nursing and Personal Care

a) The facility must 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 assessment and plan of care. 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:

b)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 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.

These Regulations were not met as evidenced by the following:

The Helia Southbelt Healthcare failed to follow their plan of correction for the survey of 1/09/09 which included that residents with pressure sores receive treatment and services to promote healing and to prevent new pressure sores from developing. .

Based on record review, interview and observation, the facility failed to turn and reposition and to provide preventive interventions for 3, (R1, R4, R6), of 5 residents reviewed with pressure

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CONT. sores, or at risk for development of pressure sores. This failure resulted in R4 developing a facility acquired, Stage III pressure sore to the coccyx.

Findings include:

1. R4's Minimum Data Set (MDS), dated 4-26-09, documents R4's cognition is moderately impaired with long term memory problems, extensive assistance of two plus staff with bed mobility, and total dependence of one to two staff for assist with transfer and toileting. The MDS assesses R4 with functional limitation in range of motion of the neck, arm, hand, leg and foot, and moderate pain, less than daily, with a Stage III pressure sore. R4's admission MDS, dated 8-19-08, documents R4 was not admitted with pressure sore(s), and she was experiencing severe pain daily, with functional limitation of range of motion in the arm and leg.

R4's Care Plans, dated 11-11-08, 2-10-09 and 4-27-09, document R4 was at risk for pressure sores with at least one care plan intervention to turn and reposition every hour (updated from two), and PRN (as needed). The Care Plan shows R4 experienced pain due to degenerative osteoarthritis, with care plan interventions to reposition for comfort, and to assess for and provide pain medication.

The facility's Weekly Wound Care Report, dated 5-4-09, documents R4 had a facility acquired, Stage III, coccyx pressure sore, which measured 3.0 cm, (centimeters) x 2.5 cm x 0.8 cm.

R4 was continuously observed sitting in her wheel chair on 5-19-09, from 9:10 a.m. to 11:10 a.m, without timely turning and repositioning. At 10:15 a.m, E9, Certified Nursing Assistant (CNA) and E10, CNA, did enter R4's room to reposition her. E9 and E10 pulled R4 up in her wheel chair, but did not provide pressure relief to R4's coccyx. At 11:10 a.m., R4 was assisted to bed. R4 stated her buttock hurt when asked. R4's adult diaper was soiled with a large amount of blood. This was confirmed during interview with E12, Licensed Practical Nurse (LPN), on 5-19-09 at 11:30 a.m. E12, LPN, stated R4's coccyx pressure dressing was soiled with blood.

During refutation, on 5-21-09, E1, Administrator, reported R4's pressure sore developed due to R4's pain, and she did not want to move as a result of her pain. R4's Care Plans, dated 11-11-8, 2-10-09 and 4-27-09, did not include pain management as a part of preventive measures to prevent the development of R4's pressure sore. R4's Pain Assessments, dated 2-10-09 and 4-27-09, did not document R4's Stage III pressure sore as part of the pain assessment.

The facility's "Management of Pain," policy and procedure, undated, documents the Comprehensive Pain Assessment should measure the impact of pain on the resident's function, assessing the resident's physical condition, history, mental state, and activities of daily living. The facility's "Pressure Ulcer Investigative Protocol," undated, shows the facility's goal was to provide care to the residents in order to prevent the occurrence of pressure ulcers, and residents who had pressure ulcers would receive treatment and services to promote healing, prevent infection and prevent further pressure ulcers from developing. The facility's Pressure Ulcer

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CONT. Investigative Protocol also documents the facility was to evaluate intrinsic risks, skin condition, and other factors which place the resident at risk for developing pressure ulcers.

2. Per The Minimum Data Set, dated 3/11/09, R6 requires extensive assistance from staff for bed mobility, transfers, and all activities of daily living. The Norton Plus Pressure Ulcer Scale, dated 3/11/09, scores R6 as a high risk for the development of pressure ulcers.

On 5/18/09, at 11:00 AM, R6 was observed laying in bed on her back, with her heels directly on the mattress. This was noted again at 2:10 PM, 2:58 PM, and 3:50 PM. Two heel protectors were observed resting on the bedside stand. At 2:58 PM, R6 was observed in bed, incontinent of bowel. After completing incontinent care, E6, Certified Nurses Aide (CNA), failed to apply a preventative barrier cream to R6's perineal area, or to float her heels.

On 5/19/09, at 10:45 AM, R6 was observed in bed without the heel protectors, or her heels floated. The heel protectors remained on the bedside stand. At 1:48 PM, E7, Licensed Practical Nurse (LPN), completed a treatment to the pressure ulcer to R6's right shoulder. The heel protectors were noted resting near the window by her bed. E7, LPN, did not float R6's heels, or apply the heel protectors. At 3:50 PM, R6 was in bed. Her heels were not floated. The heel protectors remained near the window.

On 5/20/09, at 10:37 AM, R6 was in bed on her left side. Her heels were not floated off the mattress. The heel protectors remained near the window.

A Physician's Order for R6, for 5/09, reads, "Bilateral heel protectors while in bed." The Treatment Administration Record for 5/09 documents heel protectors were applied each shift. R6's Care Plan, dated 3/11/09 reads, "Heel protectors on when in bed." The Care Plan also documents R6 with a history of an infected pressure ulcer to the left heel. The Dietary Progress Note, dated 4/07.09, shows R6's weight as 85 pounds.

The facility's policy and procedure, entitled, "Pressure Ulcer Investigative Protocol," reads, in part, "Provide pressure relief devices-in bed or chair." An objective reads, "It is the goal of this facility to provide care to the residents in order to prevent the occurrence of pressure ulcers. A resident who has a pressure ulcer will receive treatment and services to promote healing, prevent infection, and prevent further pressure ulcers from developing, in order to maintain the quality of life for that individual."

3. Per Physician's Order Sheet, for 5/09, R1 has diagnoses, in part, of Vascular Dementia, Congestive Heart Failure, Pneumonia, Acute and Chronic Respiratory Failure, and Asthma. The Minimum Data Set, dated 5/6/09, documents R1 does not have pressure sores. The Care Plan, dated 4/7/09, notes R1 was assessed as high risk for development of pressure sores, and to turn and reposition her every 2 hours.

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CONT. On 5/19/09, during the noon meal, R1 was observed seated in her wheelchair from 12:00 PM until 2:05 PM when staff took her to her room. There was no pressure relieving device in R1's wheelchair. At 2:13 PM staff assisted R1 to bed. R1 was incontinent of liquid stool. There were no new areas noted on R1's buttock but there were old healed areas to both buttocks. R1's right buttock was red.

(B)