STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146045	A. BUILDING ______ B. WING ______	12/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELIA HEALTHCARE OF ENERGY	**210 EAST COLLEGE, PO BOX 519 ENERGY, IL 62933**

(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) COMPLETION DATE
F 465	Continued From page 34 light switch; ceiling tiles were missing from the ceiling by the door. According to the facility A and B Wing - Midnight to Midnight Census, there are 26 residents on A wing and 34 residents on B wing. This was verified by E13 on 12-07-11 at 11:30 pm.	F 465		
F9999	FINAL OBSERVATIONS LICENSURE FINDINGS 300.610a) 300.1210b) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a 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	F9999		

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F9999	Continued From page 35 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: Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. 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 regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively analyze the circumstances of falls, develop interventions to prevent the recurring falls and assess interventions for 2 of 4 residents (R11,	F9999		

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F9999	Continued From page 36 R2) with falls from the sample of 15. This failure resulted in R11 sustaining a fracture to her left maxillary sinus on 10/19/11, a laceration requiring sutures to her left eyebrow on 12/11/11 and a laceration to her right eyebrow on 12/12/11. Findings Include: 1. According to R11's Nurse's Notes, R11 was admitted to this facility on 07/16/11. Upon review of R11's History and Physical dated 07/16/11, R11 is a 74 year old female with a diagnosis of Alzheimer's and Dementia. The facility's "Fall Risk Assessment" for R11 dated 10/21/11 shows that R11 has a risk score of 16. Documentation of the Fall Risk Assessment states that if the total score is 10 or greater, the resident should be considered at high risk for potential falls and a prevention protocol should be initiated immediately and documented on the care plan. Per review of R11's Physical Therapy Discharge Note dated 10/04/11, documentation states that a restorative program has been created for R11. Upon review of R11's "Restorative Care Program" dated 10/05/11, documentation states, "Use gait belt." "Monitor while ambulating to improve safety." Review of the facility's incident reports show that R11 fell on 07/25/11, 10/15/11 and 10/17/11. Documentation also states that R11 did not receive injuries as a result of these falls.	F9999		

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F9999	Continued From page 37 Although R11 sustained falls, the facility failed to put interventions in place to prevent further falls on the care plan until another fall occurred on 10-19-11. 10/19/11 - 1:45 p.m. - "74 year old female. Dx: Dementia - independently ambulatory. Walking in A - wing hall. Walked around corner and tripped over scale, tried to grab handrail to catch herself but lost balance and hit head on floor. Laceration above left eye. Sent out to ER for eval. Incident witnessed by staff, staff unable to get to resident before she fell. Neuro checks initiated." Res sent to ER" Investigative Results for R11's 10/19/11 fall at 1:45 p.m. state, "Tripped over scale, losing balance. Scale moved to B - wing foyer. Physical Therapy notified for possible eval. (Name of Physician) to review meds. Neuro checks - Obtained fx of left maxillary sinus (Name of Physician) to follow." R11's Plan of Care, dated 10/19/11 states, "Resident is at risk for falls r/t (related to): Wanders s (without) purpose. Resident has a dx of Dementia (had 3 prior falls)..." The facility's approaches to R11's risk of falls states, "Call light within reach while in room, Instruct/remind res to call for assist with mobility/transfers as needed, Clutter free environment, Proper footwear as indicated, Use of proper assistive device, Wheelchair/walker as needed, Cues/redirect as needed, Rest periods as needed, Invite/escort to activities of choice as tolerated as desired, Observe for safety." During interview with E13 (Licensed Practical	F9999		

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F9999	Continued From page 38 Nurse) on 12/15/11 at 2:30 p.m., E13 stated that Physical Therapy has not re-evaluated R11 as indicated on the facility's incident report dated 10/19/11. Per observations on 12/09/11, from approximately 10:30 a.m. until 4:00 p.m., R11 was noted to be independently ambulating and wandering around the facility almost constantly. Upon entering the facility on 12/13/11 at approximately 8:30 a.m., surveyor observed that R11 had 2 black/purple eyes, a laceration above each eye and a bruise to her left cheek. During interview with E2 (Registered Nurse/Director of Nurses) on 12/13/11 at 10:00 a.m., E2 said that R11 had fallen on 12/11/11 and had been sent to the emergency room where she received 3 sutures above her left eyebrow. The facility's incident report 12/11/11 states that at 7:20 a.m., "Res observed in floor between ARCH et (and) Helia on L side c (with) laceration to L eyebrow. Res c/o pain et says she's unable to get up. Res sent to ER..." Documentation continues to say that R11 received 3 sutures to her left eyebrow. This incident report also says that R11 appeared to have tripped over an area rug in the foyer. The Care Plan dated 12-11-11 indicates that the only intervention put in place after this fall was that staff were to re-direct R11 as soon as she is seen leaving her comfort zone which includes area not within staff's eyesight and remove the area rug.	F9999		

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F9999	Continued From page 39 Documentation in R11's Nurse's Notes dated 12/12/11 at 10:00 a.m. states, "Res up amb c unsteady gait..." R11's Nurse's Notes dated 12/12/11 at 11:00 a.m. states, "...Res was seen in floor in her room down on her hands & knees. Noted 3 cm (centimeter) laceration to ^ (upper) R eyebrow. Area cleaned drsg applied..." There is no evidence that the facility investigated as to why or how R11 fell. The Care Plan dated 12-12-11 indicates that the only intervention put in place after this fall was that R11's bed was moved to the lowest possible position. R11's table and drawer were moved to decrease clutter in the room. Per interview with E2 (Registered Nurse/Director of Nurses) on 12/13/11 at 10:00 a.m., E2 stated that R11 is independent in ambulation and wanders constantly. When asked about R11's Restorative Care Program recommending the use of a gait belt, E2 said that R11 refuses to allow staff to use a gait belt. E2 also stated that there is no documentation that shows the facility attempted to follow R11's Restorative Care Program. During continuing interview with E2 on 12/13/11 at 10:00 a.m., when asked how staff are to monitor R11 while ambulating as per R11's "Restorative Care Program" E2 said, "We don't have 1 staff person continually monitoring her 24 hours a day - all staff monitor her when she is in their area. All staff keep an eye on her." 2. According to facility Incident Reports, R2 experienced falls on 5/7/11, 5/17/11, 5/23/11,	F9999		

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F9999	Continued From page 40 6/7/11, 7/14/11, 8/15/11 and 9/12/11. According to the incident report dated 6/7/11, R2 was evaluated by therapy post fall and, and in order to prevent further incidents "walker now used for stabilizer." According to the incident report of 8/15/11, R2 fell in the hallway, while ambulating wearing rubber flip flops, not using a walker, and sustained a hematoma to the right forehead. The report indicates that the fall was witnessed: however the witness' name is left off of the report. The intervention to prevent a recurrence states, "staff removed unsafe shoes from resident's room with her approval."	F9999		