STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145241	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helia Southbelt Healthcare	101 South Belt West Belleville, IL 62220

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview, observation, and record review the facility failed to provide and implement fall interventions as care planned for 4 of 5 (R1, R2, R4, R5) residents reviewed for accidents. R1's face sheet, print date 7/3/24, documented R1 was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, dementia, epileptic seizures, heart disease, type 2 diabetes mellitus, and depression. R1's MDS (Minimum Data Set), dated 5/10/24, documented that R1 is cognitively intact. R1's care plan, undated, documented that R1 is at risk for falls related to an unsteady gait and that R1 is to have the following interventions in place: reminder signs placed to remind to use call light for assistance, canoe mattress on bed, and dycem in her wheelchair to prevent sliding. R1's EMR (Electronic Medical Record) progress note dated 12/22/23 at 10:03 am documented resident observed on floor. Resident stated she was sleeping and rolled out of bed. Injury (hematoma) noted to left side of forehead. Resident stated her pain level is at a 5. Tylenol and ice given. NP (Nurse Practitioner) is here, new order to send to ER (emergency room) for evaluation and treatment. R1's EMR progress note dated 2/4/24 at 7:39 pm documented resident had an unwitnessed fall. When asking resident what happened resident states, she was trying to self-transfer herself into bed. Resident states she hit her head against her bed. No injuries noted. R1's EMR progress note dated 2/5/24 at 7:25 pm documented resident sent to ER for complaint of left rib pain, and headache. Displayed altered mental status and dehydration. Resident has fractured left rib and fractured great right toe. MD notified. Resident sent back via EMS (Emergency Medical Service) with new order of lidocaine 4% patch daily. R1's progress note, dated 3/28/24 at 3:35 am documented the resident was observed on the floor on her buttocks attempting to transfer self to the restroom. When the resident was asked, she stated that she was having neck and head pain. Upon assessment, the resident had a small knot on the left side of forehead, but no other injuries found. The resident stated her pain was an 8 on a 0-10 numeric scale. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's progress note dated 4/12/24 at 7:11 am documented resident was observed on the floor attempting to transfer self from bed to wheelchair. Resident stated that her bottom was a bit sore but refused pain medication. No marks or bleeding upon assessment. R1's progress note dated 4/12/24 at 9:27 am documented immediate intervention reminder signs placed in room to use call light and ask for assist, when interviewed she stated she had no pain. On 7/2/24 at 9:40 am R1 was observed sleeping in her bed on a regular mattress not a canoe mattress as care planned. R1's room did not have any reminder signs posted to use call light for assistance as her care plan documented. R1's wheelchair was sitting next to her bed, and it did not have dycem placed over the cushion as care planned. On 7/2/24 at 12:30 PM V8 CNA (Certified Nurse Assistant) assigned to R1 stated that R1's only fall interventions that she is aware of is R1 is supposed to be supervised and is supposed to have a gait belt on during transfers. On 7/3/24 at 10:35 am R1 was observed sitting up in her wheelchair. R1's wheelchair did not have dycem in the seat. R1 stated she does not recall ever having it. R1's assigned CNA, V8 stated she does not recall ever seeing dycem in R1's wheelchair. R2's face sheet, print date 7/3/24, documented R2 was admitted to the facility on [DATE] with diagnoses hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, heart disease, chronic kidney disease, cellulitis of left lower limb, abnormalities of gait and mobility, and osteoarthritis. R2's MDS, dated [DATE], documented R2 is cognitively intact. R2's care plan, undated, documented resident is limited in ability to walk in room. Requires assistance of 1 with wheeled walker. Resident will ambulate in room with assistance and required device. Resident is at risk for falls related to recent hospitalization , generalized weakness, and deconditioning. Requires assist with ambulation, gait unsteady. Approach: provide resident an environment free of clutter and provide toileting assistance, requires assist of R2s EMR progress note, dated 3/16/24 at 3:21 pm, documented resident observed on floor in bathroom, when asked what happened resident stated she was going to the bathroom. Resident was assisted into wheelchair by 2 staff members, immediately assessed with no injuries. R2's EMR progress note, dated 6/24/24 at 11:55 pm, documented resident noted on the floor in bathroom. Resident was attempting to self-transfer and became weak and had a fall per resident's statement. Resident assessed and noted to have a skin tear to left forearm as well as left dorsal hand. Resident also have a hematoma noted to the crown of head. It continued; ROM (range of motion) within normal limits, resident was assisted to wheelchair by nurse and CNA. At the time of transfer resident was incontinent with one shoe off, no grip sock on left foot. resident transferred to local hospital via EMS. R2's EMR progress note, dated 7/2/24 at 1:39 pm, documented resident is alert and oriented times 4. Resident had unwitnessed fall in bathroom. Upon assessment no injuries noted. It continues, no socks and shoes on left foot. No shoes nor socks noted on right foot. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/2/24 at 12:35 pm R2 was observed ambulating out of her bathroom unassisted with bare feet. R2's room was observed to be cluttered with the following items on her floor around her bed and recliner: a large weave basket full of items, a large plastic basket, 5 plastic bags full of items, 2 large potato chip boxes, a 12 pack of soda, a large blanket, 3 magazines, a full trashcan with the contents overflowing onto the floor, and a large plastic storage tote. R2's EMR did not document any education nor assistance provided to the resident regarding the importance of a clutter free environment as care planned nor did R2's care plan address proper footwear during ambulation. On 7/3/24 at 0915 am R2 stated that facility staff have not offered her any assistance with organizing her room nor in offering other personal storage arrangements for her large number of belongings. R2 had a bandage on her left hand and a bandage on her left arm. R2 stated that she had obtained skin tears to her left hand and arm from a prior fall. R4's face sheet, print date of 7/3/24, documented R4 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, chronic obstructive pulmonary disease, atrial fibrillation, chronic kidney disease, hypertensive heart disease, reduced mobility, need for assistance with personal care, and frontal lobe function deficit. R4's MDS, dated [DATE], documented R4 is severely cognitively impaired. R4's care plan, undated, documented resident is at risk for falling related to cognitive impairment, decreased safety awareness, impulsiveness with attempts to stand or self-transfer without assistance. This care plan documented approach: provide proper, well-maintained footwear, non-slip socks in bed while shoes are not on. R4's EMR progress noted, dated 4/29/24 at 3:47 am, documented this nurse was alerted by the CNA that the resident was observed on the floor in his room by his bed. Upon entering the resident's room, this nurse observed the resident sitting on the floor facing the door, with his back against his bed. This nurse asked the resident why he was sitting on the floor, the resident states, I was trying to sit on the side of the bed, and I felt my feet slide and I started to slip of the side of the bed, so I lowered myself to the floor and just sat here. The resident had regular socks on at this time. It continues, the immediate nursing intervention is to have resident's bed in the lowest position at all times while resident is in it and that resident is to have no slip socks on while in bed, and while he doesn't have shoes on. On 7/2/24 at 1:18 pm R4 was observed sleeping while sitting up at his bedside with his head resting on his bedside table and R4 had his feet placed on the floor. R4 was wearing regular white socks. R4 did not have shoes nor gripper socks on as documented in his care plan. R5's face sheet, print date 7/3/24, documented R5 was readmitted to the facility on [DATE]. R5's census sheet documented an original admitted [DATE]. R5's face sheet documented R5 has diagnoses of fracture of right humerus, muscle weakness, osteoporosis, unsteadiness on feet, need for assistance with personal care, cognitive communication deficit, age-related cognitive decline, hypertension, congestive heart failure, type 2 diabetes mellitus with diabetic nephropathy, chronic obstructive heart disease, osteoarthritis, and chronic respiratory failure with hypoxia. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's care plan, undated, documented resident has potential for falls or trauma related to gait instability, muscle weakness, ADL (activities of daily living) dysfunction, and debility contributing diagnosis: respiratory failure, anemia, COPD (chronic obstructive pulmonary disorder, CHF (congestive heart failure), and cellulitis of right foot with an approach of floor mat placed beside bed. R5's MDS, dated [DATE], documented R5 is cognitively intact. R5's EMR progress note, dated 1/17/24 at 1:30 am documented resident found on the side of bed. Complained of pain and discomfort to neck, right elbow, and right shoulder. Attempting to perform range of motion. Resident grimaced and yelled in pain. 911 called and report given, 2 EMTS arrived at this time to transport to local hospital. R5's progress note, dated 1/17/24 at 9:33 am, documented sent to ER, it continues bedside mat to be placed prior to return from hospital. R5's progress note, dated 1/26/24 at 8:34 am, documented resident interviewed this am after return from hospital post fall, resident states that what she remembers is feeling as though she was falling when she was repositioning in bed, states I felt like I was falling from a chair. Diagnosis of proximal right humerus fracture at hospital, immediate intervention was mat to bedside. On 7/2/24 at 1:20 PM, R5 was observed in bed with high humidity oxygen running to her tracheostomy. Resident did not have a mat on her floor nor anywhere in her room. R5 shook her head no when asked if she ever has a floor mat next to her bed. On 7/3/24 at 10:30 AM, R5 was again observed in bed and neither side of the bed had a mat placed next to it. R5's assigned CNA, V9 and V10 stated that R5 has never had a mat next to her bed nor are they aware of her having it in her care plan. On 7/3/24 at 8:35 AM, V3, CPC (Care Plan Coordinator) stated that any fall interventions on the care plan are supposed to be in place for each resident. On 7/3/24 at 11:07 AM, V2, DON (Director of Nursing) stated that the fall interventions listed in the residents' care plans should be in place. The facility's Falls Management policy, dated July 2017, documented it is the policy of Helia Healthcare to assess and manage resident falls through prevention, investigation, and implementation and evaluation of interventions. It continues, 1. A fall risk assessment will be completed on all residents upon admission, re-admission, after each fall and quarterly thereafter. 2. Resident's identified as high risk will have fall prevention addressed on the plan of care.