STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145290	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belleville Healthcare Center	727 North 17th Street Belleville, IL 62226

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 - Few	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** 45947 Based on observation, interview, and record review, the Facility failed to provide the necessary physician-prescribed supervision to prevent elopement and falls for 3 of 4 residents (R3, R1, R7) reviewed for one-on-one supervision in the sample of 7. Findings include: 1. R3's Face Sheet documents R3 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, alcohol abuse, cerebral infarction and dementia with behavioral disturbance. R3's Minimum Data Set (MDS) dated [DATE] documented R3 was moderately cognitively impaired and required supervision or touching assistance with mobility. R3's Undated Care Plan documents R3 is at high risk for elopement related to vascular dementia. R3's Elopement Evaluation dated 4/18/24 documented R3 was at high risk for elopement. R3's Physician Order dated 5/1/24 documents, 1:1 for elopement safety with no order end date. R3's Progress Notes document R3 has attempted to leave the Facility on 5/18/24, 5/19/24, 5/20/24, 5/26/24, and 5/27/24. R3's Progress Note dated 5/20/24 at 9:29 PM documents, Staff notified nurse that boyfriend put resident in car after sitting in front of building and drove away without notifying any staff members at 7pm. Staff members went outside into parking lot several times to see if we seen (sic) the resident and the vehicle that boyfriend drives and did not see vehicle. This writer called niece to see if made aware niece stated she did not know and did not want him to leave with her. Niece gave a call back and stated that she tried to give him a call, but he would not answer. Boyfriend returned with her at 8pm. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 - Few	On 10/18/24 at 1:58 PM, V34, CNA, stated she worked on R3's hall on the evening of 5/20/24. She recalls passing dinner trays around 6:00 PM where V31 (R3's Friend), was in the room eating dinner with R3. She stated around 6:30 PM, V31 took R3 outside to the patio area to smoke, and then he left with her in his car. V34 told V33, Licensed Practical Nurse (LPN), who contacted V35 (Former DON), V20 (R3's Power of Attorney POA), and V31. V33 told V31 if he did not bring R3 back she was going to call the police. V31 brought R3 back around 7:30 or 8:00 PM. V34 stated she had no idea where they went or what they did. She added it was not unusual for the two of them to go outside and smoke or sit in V31's car without staff present. She stated R3 is 1:1 but when family comes, they often set up the room and let the residents visit with family. On 10/18/24 at 2:25 PM, V2, DON, stated V33, LPN, no longer works in the Facility and has no way of getting in contact with her. On 10/16/24 at 8:05 AM, V2, DON, stated this incident happened before she started working here, and there is no investigation because V31 is R3's boyfriend of 30 or more years. She stated V31 visits R3 every day, and they just sit together in his vehicle in the parking lot to smoke cigarettes and visit. On 10/17/24 at 9:35 AM, V17, Certified Nursing Assistant (CNA), stated R3 likes to go outside with visitors. They go outside and sit in their car for a couple hours. When they go outside, staff do not have to go with them. When they are in R3's room, V31 leaves the door open so staff can check on them from time to time. R3 is independent with walking, and when she gets up the first thing she does is walk over to the window like she wants to go out. On 10/17/24 at 10:50 AM, V23, CNA, stated R3 wanders, so she requires 1:1 supervision. She stated when R3 and V31, R3's Friend, go outside and visit in V31's car staff look out every hour or so to check on them. She stated V31 visits R3 almost daily between 3:30 and 4:00 PM and stays through dinner. On 10/18/24 at 8:21 AM and 11:14 AM, attempted to contact V31, R3's Friend, by phone with no response. On 10/18/24 from 3:20 PM through 4:55 PM, periodically attempted to visit V31, R3's Friend, in R3's room, but V31 was not present. On 10/17/24 at 2:29 PM, V26, Nurse Practitioner (NP), stated R3 has questionable decision making capacity, is an elopement risk and requires 1:1 supervision, so she is unsafe to be outside the facility without supervision. R3's Progress Note dated 9/15/24 at 7:06 PM documents, This resident fell out of the bed and was sitting next to her bed. Resident able to move all extremities. Resident able to bend knee, no external rotation noted. Resident denies pain. Resident is noted to have dementia and is a poor historian of how she fell out of the bed. Resident noted to have one-on-one sitting. This nurse had called scheduler to check on status of one-on-one sitter to arrive to facility. Staff sitter did arrive shortly after and stayed with her one-on-one. On 10/17/24 at 8:05 AM, V2, DON, stated she does not have a fall investigation for R3's 9/15/24 fall to explain the circumstances surrounding the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/24 at 5:39 PM, V20, R3's Power of Attorney (POA), stated the Facility is not doing a good job with the continuous one-on-one monitoring because no staff were with R3 when she had the fall. On 10/17/24 at 2:02 PM, R3 was lying in bed in her room with the door closed. There were no staff members present in R3's room. On 10/17/24 at 2:07 PM, V23, CNA, entered R3's room and closed the door behind her. On 10/17/24 at 2:08 PM, V2, DON, knocked on R3's room, entered the room, and stated to V23, Where is she? while closing the door behind her. 2. R1's Face Sheet documents R1 was admitted to the facility on [DATE] with diagnoses including encephalopathy and delirium. R1's MDS dated [DATE] documented R1 required supervision or touching assistance with ambulation. The MDS did not assess R1's level of cognition. R1's Undated Care Plan documents R1 is at risk for elopement and walked out of the Facility against staff directives. The intervention added 10/4/24 was 1:1 (One-on-One Supervision) with staff. R1's Progress Note dated 9/30/24 at 10:13 AM documents, This morning at 7:15am this nurse was notified by another staff member that the resident had escaped out the door. Staff members immediately ran after the resident to bring him back to safety. Once outside resident had a wet floor sign and attempted to hit every staff member outside with it. Staff able to get wet floor sign from resident and once sign was removed from residents' possession and the resident started swinging his fists at staff. Resident then assisted back to parking lot and resident then sat on the ground and would not get up. 911 notified. Resident then kept swinging while on the ground. On 10/18/24 at 9:05 AM, V2, DON, stated staff were right behind R1 when he exited the Facility. R1 became violent, swinging at staff and punching a staff member in the face and was sent to a psychiatric hospital for evaluation. On 10/18/24 at 9:16 AM, V32, CNA, stated he saw R1 walk past him in the basement and thought R1 was going to the vending machine. V32 then heard the door alarm go off and discovered the door was open and R1 was out in the parking lot. V32 called other staff members for assistance, and he returned to his job duties after the police and ambulance arrived. R1's Elopement Evaluation dated 10/8/24 documented R1 was at high risk for elopement. R1's Physician Order dated 10/4/24 documents, 1:1 for enhanced monitoring r/t (related to) elopement risk with no order end date. On 10/16/24 at 7:45 AM, V4, CNA, came to the front door of the Facility to unlock and open the door for IDPH Surveyor and V13, Agency CNA. He then walked to the 300 Hall and into R1's room. He stated he was going to monitor (R1) until someone else came in to take over. 3. R7's Face Sheet documents R7 was admitted to the facility on [DATE] with diagnoses including head injury, violent behavior, and history of falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R7's MDS dated [DATE] documented R7 was severely cognitively impaired and required supervision or touching assistance with ambulation. R7's Undated Care Plan documents R7 has a history of falls and is at high risk for falls. The intervention added on 9/16/24 documents, Educate staff to stay close by at all times as resident is 1:1. The Care Plan documents R7 is at risk for elopement related to increased confusion. R7's Physician Order dated 10/3/24 documents, Enhanced monitoring: 1:1 monitoring r/t weakness and increased falls with no order end date. On 10/16/24 at 7:45 AM, V4, CNA, came to the front door of the Facility to unlock and open the door for IDPH Surveyor and V13, Agency CNA. V13 went to R7's room where there were no other staff present. V13 stated she was running late today and was supposed to be here at 6:30 AM. She did not know who was monitoring R7 before she got there, but she checked the Enhanced Supervision Monitoring Tool which documented the last monitoring was completed at 5:45 AM by V25, Agency CNA. On 10/17/24 at 8:05 AM V2, DON, stated V25, Agency CNA, left the building without notifying the nurse there was no staff to continue monitoring R7. V2 stated she will be providing staff in services today regarding 1:1 supervision. The Facility's Resident Rights & Residents' Safety Enhanced Supervision Guidelines revised 7/8/20 documents, One to one observation - one staff member will be scheduled to provide one to one observation. The scheduled staff member will not have other resident in his/her care assignment. This is an integral part of a therapeutic plan and ensures the safe and sensitive monitoring of the patients' physical and psychological well-being, whilst at the same time developing positive therapeutic interactions. It should consider interactions and engagements with the patient that maintains a balance between intrusion and safety. The Facility's Elopement Policy reviewed 1/21 documents, Elopement is defined as a situation where a resident who cannot recognize normal dangers and hazards outside the facility leaves the facility without staff knowledge. Residents who are at high risk to elope are closely supervised to keep them safely in the facility, while allowing them to move freely about the facility. The Facility's Fall Prevention and Management Policy revised 8/2024 documents, This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible. The Policy also documents an incident report should be completed following a fall.