

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Belleville Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108</p> <p>Based on interview and record review the facility failed to monitor and supervise 1 of 3 residents (R4) reviewed for elopement in a sample of 10. This failure resulted in R4 leaving the facility unattended, on 12/20/2024 from 2:00 AM to 3:30 AM, falling outside the facility, sustaining multiple abrasions to both lower extremities, a dislocated left wrist, and a laceration to R4's forehead and left cheek that required sutures.</p> <p>The Immediate Jeopardy began on 12/20/2024 when R4 eloped from the facility without staff knowledge. R4 was last seen in the facility on 12/20/2024 2:00 AM and was found outside the facility on the ground. Due to R4 physical and cognitive vulnerabilities, R4 had the likelihood of serious harm and injury when R4 eloped. V1, Administrator, and V30, Regional Clinical Nurse, were notified of the Immediate Jeopardy on 1/3/2025 at 2:50 PM. Surveyors confirmed by observation, record review, and interview, the Immediate Jeopardy was removed 1/7/2025 but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of staff's in-service training, and implementation of interventions for those at risk for elopement.</p> <p>Findings include:</p> <p>R4's diagnoses are Unspecified Injury of Head, subsequent encounter, Bipolar Disorder, History of Falling, Violent Behavior.</p> <p>R4's Care Plan, dated 10/17/2024, documents Resident is at risk for elopement r/t (related to) increased confusion. 10/17/2024 15-30 min checks as needed (PRN). Monitor where abouts PRN. 12/20/24 resident assessed, BPD called resident sent to (local) hospital for eval and treatment. Medication review upon return to facility.</p> <p>R4's Minimum Data Set, dated [DATE], documents that R4 is severely cognitively impaired.</p> <p>R4's August and November 2024 Elopement Assessments, documented R4 was at high risk for elopement.</p> <p>The facility's Elopement Book, located at the 300/400 hall nurse's station, documents Elopement Evaluation, dated 8/20/2024 High Risk, R4's Picture on Resident Elopement Risk Information with description of R4 and Admission Record.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Per National Weather Service on 12/20/2024 from 2:00 AM to 4:00 AM it was 32- 36 degrees Fahrenheit.</p> <p>R4's Incident Report, dated 12/20/204, documents that R4's mental status was confused/forgetful, not oriented. Predisposing Physiological Factors: poor trunk control, gait imbalance, impaired memory. Predisposing Situation Factors: Active Exit Seeking</p> <p>R4's Progress Note, dated 12/20/2024 at 3:30 AM, documents Nurses Notes Note Text: This nurse was on break and I then received a phone call from 300 hall CNA(Certified Nursing Assistant) stating that resident eloped and was found outside the building by staff; resident confused and forgetful; resident has a laceration to the forehead and abrasions to his arms and legs; 911 immediately notified; DON (Director of Nursing) notified; Administrator notified; Resident transferred to (local) Hospital in Belleville; plan of care continues.</p> <p>R4's Local Hospital Emergency Department report, dated 12/20/2024, documents History of Present Illness Chief Complaint Patient presents with Fall 9:16 AM (R4) is a 65 y.o. (year old) male presenting to the ED (emergency department) c/o (complaints of) fall onset PTA (Prior to Arrival). EMS (emergency medical service) states pt (patient) came from NH (nursing home) where he hit staff there. He ran away, tripped, and hit his head on the ground. He has multiple abrasions to BLE (bilateral lower extremities). Also has a few lacs (lacerations) to his left side of face. Sutures to R4's forehead and cheek.</p> <p>R4's Progress Note, dated 12/20/2024 at 10:37 AM Nurses Notes Note Text: Resident returned from (local) hospital r/t fall with laceration to face. Resident is up with walker. Skin w/d to touch. Rest(sic) even unlabored. No c/o pain or SOB noted. Resident agreed to take a shower and after will speak to his ex-wife via phone.</p> <p>R4's State of Illinois Department of Public Health Long-Term Care Facility & 110 - Serious Injury Incident and Communicable Disease Report, dated 12/20/2024, documents staff noted resident was agitated all evening shift. nurse stated that she tried to redirect him from doors and when she did this, he tried to hit staff. staff noted the last time seen was 2:30am. around 3:00-3:30am staff noted resident outside of facility and resident had fallen. staff brought him into facility. nurse completed assessment. he had multiple lacerations on face and abrasions on legs. staff denied hearing any door alarms going off. resident was sent to ER for evaluation and returned with sutures in one laceration.</p> <p>R4's Progress Note, dated 12/21/2024 at 5:19 PM, documents Nurses Notes, Note Text: Resident Left wrist is bruised and swollen and will point to the left wrist area when you ask where it hurts. Resident has kicked one staff member and another resident. NP (Nurse Practitioner) notified, (local) ambulance and (Local) pd notified.</p> <p>R4's Local Hospital After Visit Summary, dated 12/21/2024, documents Reason for visit: Altered Mental Status. Diagnosis Dislocation of wrist and aggressive behavior. It also documented Patient Education for Preventing falls in adults.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 1/3/2025 at 10:48 AM V13, CNA, stated that she was there when R4 fell outside. V13 stated that R4 was having behaviors and was trying to leave the building. V13 stated that this was several times throughout the shift. V13 stated that she had taken R4 to his room several times and he would go back to the door. V13 stated that she had taken R4 back to his room. V13 stated that she did not stay with R4. V13 stated that she did not increase supervision but did address the behaviors when she was aware. V13 stated that the last time she saw R4 was around 2 AM. V13 stated that she was told that R4 was outside about 3:30 AM. V13 stated that she went outside to help. V13 stated that R4 was on the side of the building. V13 stated that she put R4 in her truck and drove R4 around to the entrance. V13 stated that R4 did not say what happened he would just keep saying he was so cold.</p> <p>On 1/3/25 at 4:52 PM V15, CNA, stated that R5 notified him he saw someone outside his window. V15 stated that he looked out R5's window and saw R4 outside on the ground. V15 stated that R4 was struggling trying to get up off the ground. V5 stated that he went up and got help and went outside and helped R4 up and inside the building. V15 stated that R4 did not say how he got out or what happened. V15 stated that once R4 was in the building he went back to his work area.</p> <p>The facility's Elopement Policy, dated 9/2022, documents DEFINITION/GENERAL: Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. Elopement Risk: If the cause of the alarm is the resident attempting to leave the unit, the following measures will be taken: a. Resident will be redirected to the unit b. Additional monitoring of the resident as appropriate c. Update care plan as appropriate.</p> <p>The facility presented an abatement plan to remove the immediacy on 1/3/2025. During the validation of the abatement by the survey team on 1/7/2025, review of enhanced monitoring revealed that monitoring was not being completed per abatement plan, multiple interviews with staff indicated that they were not in-serviced, inspection of exit doors and alarms revealed that they were not working properly. At 3:07PM, the facility provided an updated abatement plan to reflect the exit doors and alarms were monitored and working; and documentation that all staff were in-serviced as of 1/7/2024.</p> <p>The Immediate Jeopardy that began on 12/20/2024 was removed on 1/7/2025, when the facility took the following actions to remove the immediacy. The facility provided an abatement plan that included the following:</p> <p>1. Affected resident corrective actions</p> <p>RESIDENTS:</p> <p>A. R4 placed on Enhanced Monitoring.</p> <p>B. Any Residents with High Elopement Risk Assessment will be placed on Enhanced Monitoring. a. Enhanced monitoring will include but not limited to behavior monitoring every shift and 15 to 30 min location checks on residents that are exhibiting exit seeking behaviors.</p> <p>C. All residents have the potential to be affected by the alleged deficiency.</p> <p>2. Immediate Actions: Initiated 1/3/2025</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>J. As part of monitoring, the Administrator/Designee will monitor through facility audit tools daily x 5 days for 1 week and then weekly x 4 weeks to ensure any resident with moderate to high elopement risk assessment are monitored and supervised appropriately.</p> <p>K. New Admit residents will be assessed upon admission and residents exhibiting new onset exit seeking will be reassessed and based on assessment findings will be added to elopement binders and behavior monitoring.</p> <p>Date Facility Asserts Likelihood for Serious Harm No Longer Exists: Completion Date: 1/7/25</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42108</p> <p>Based on observation and interview, the facility failed to maintain an effective pest control program related to bed bugs in the facility for 1 of 2 units observed.</p> <p>Finding includes:</p> <p>The Local Exterminator Invoice, 12/21/2024, documents Bed Bug Conventional Treatment- Corrective.</p> <p>On 1/2/2024 at 9:29 AM 500 hall was inspected. One room had 4 bait stations with multiple bedbugs on each bait station. Another Room had 4 bait stations with multiple bedbugs in each station. A white powdery substance was on the floor with dead bedbugs on the floor.</p> <p>On 1/2/2024 at 9:20 AM V10, Maintenance Director, stated that they have had bedbugs in the facility. V10 stated that they had a local exterminator company come in and treat. V10 stated that they set traps and moved the residents out of the rooms. V10 stated that they currently have activity. V10 stated that they got the go ahead today from corporate to do a heat treatment. V10 stated that they are waiting on bids.</p> <p>R10's Minimum Data Set (MDS), dated [DATE], documents that R10 is cognitively intact.</p> <p>On 1/2/2024 at 9:39 AM R10 stated that he had recently seen bed bugs in his room. R10 stated that he was previously in a room and they were everywhere. R10 stated that they were keeping him up at night. R10 stated that he is not sure if they were biting him or crawling on him, but they just kept him awake.</p> <p>R11 's MDS, dated [DATE], documents that R11 is cognitively intact.</p> <p>On 1/2/2025 at 9:43 AM R11 stated that he has seen a couple of them on his bed and had to kill them.</p> <p>On 1/2/2025 at 9:50 AM V22, Housekeeper, stated that the facility has bedbugs and he seen the bedbugs on the left side of 500 hall.</p> <p>On 1/2/2025 at 9:53 AM V21, Licensed Practical Nurse (LPN), stated that she has not seen any bedbugs recently. V21 stated that she had seen some in the past. V21 stated that there has been an exterminator, and the residents were moved out the room.</p> <p>On 1/2/2024 at 10:04 AM V24, Maintenance Assistant, stated that the facility has a current bedbug problem located on 500 hall. V24 stated that the bedbugs are active at this time.</p> <p>On 1/2/2025 at 2:56 PM V8, LPN, stated that the facility has bed bugs. V8 stated that the bed bugs are currently active in the facility. V8 stated that they are on 500 hall the 1st, 2nd, and 3rd rooms. V8 stated that R9 was walking through the building with bed bugs dropping off his body. V8 stated that the facility has been treating but it's not helping.</p> <p>(continued on next page)</p>		

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