PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			, ,		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BU B. WII			С	
		145289	D. WII	· · ·		10/0	5/2011
	PROVIDER OR SUPPLIER EALTHCARE OF BEL	LEVILLE		4	REET ADDRESS, CITY, STATE, ZIP CODE 40 NORTH 64TH STREET BELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	ГS	F	000			
	Complaint Investig 1142700 (IL 54351 F157, F224, F253, 1142666 (IL 54311 F309, F312, F314,) F309, F314)					
F 157 SS=D		IFY OF CHANGES	F	157	,		11/4/11
	consult with the resknown, notify the resor an interested far accident involving tinjury and has the pintervention; a signiphysical, mental, or deterioration in heastatus in either life clinical complication significantly (i.e., a existing form of treaconsequences, or treatment); or a decite resident from the \$483.12(a). The facility must alsand, if known, the resident from the resident from the facility must alsand, if known, the resident from the facility must alsand, if known, the resident from the facility must alsand, if known, the resident from the facility must alsand, if known, the resident from the facility must alsand.	ediately inform the resident; ident's physician; and if esident's legal representative nily member when there is an he resident which results in potential for requiring physician ificant change in the resident's resychosocial status (i.e., a lith, mental, or psychosocial threatening conditions or eas); a need to alter treatment need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge ne facility as specified in					
	or interested family change in room or specified in §483.1 resident rights under regulations as specithis section.	member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of cord and periodically update					
I ABORATOR	-	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE

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.

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F 157	This REQUIREMENT by: Based on interview facility failed to prort 1 of 6 residents (R1 notification in the safetiment of 8 residents (R1 not 1 notification in the safetiment of 8 residents (R1 not 1 notification of 8 residents (R1 not 1 notified of 8 residents (R1 not 1 notified of 8 residents (R1 notified 8 residents	one number of the resident's or interested family member. NT is not met as evidenced of an and record review, the inptly notify the physician for reviewed for physicain ample of 6. a Set (MDS) dated 7/28/11 at 69 year old female admitted 1/11 with diagnoses of Anxiety, Tracheostomy, Fibrillation, Morbid Obesity, MDS indicates she is requires extensive to total as of Daily living (ADL's.). The ses noted dated 7/24/11 at 1) noted to have 2 areas on at 1.8cm x 1.2 x 0.2, L (left) oriation to thighs." The red and treatment orders are to R inner bigger in size 2.5 x 2.2 x 2" rentation R1's physician was add deteriorating on 7/29/11. In interview with E2, Director on 10/4/11 at 1:50pm.	F	157	,		
	notes until 8/4/11, 6 that "all previous or	ner entries into the nurses days later, which documents ders dc"d (discontinued) new The August 2011 POS					

Facility ID: IL6006704

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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F 157 F 224 SS=G	thigh wounds for Sacleansing with norm needed.) There is a physician was not or decline was noted. On 8/15/11, the began exhibiting into and elevated temperature the hospital on 8/17 cellulites, urinary tra 483.13(c) PROHIBI MISTREATMENT/NN The facility must depolicies and proced mistreatment, negle	change dated 8/4/11 to both antyl and Silver Alginate after nal saline daily and PRN (as no explanation as to why the notified previously when the on 7/29/11, 6 days earlier. nurses notes indicate R1 creased confusion, lethargy erature. She was admitted to 7/11 with pressure ulcers and act infection and sepsis. T		2224			11/4/11
	by: Based on interview neglected to identify pressure ulcers for for pressure ulcer to sample of 6. This for developing a fever, wound odor, and R room, and found to ranging from stage what the facility was	AT is not met as evidenced and record review, the facility y, assess, and treat multiple 1 of 4 residents (R4) reviewed reatment and prevention in the ailure resulted in R1 confusion, lethargy and 1 was sent to the emergency have more pressure sores III's to necrotic areas than a saware of. R1 underwent wounds on 8/25/11.					

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F 224	The Minimum Didentifies R1 to be to the facility on 5/3 Respiratory Failure Gastrostomy, Atria and Anemia. The lalert/oriented and rassist of all Activitie According to labs of Total Protein 5.7 (Nalbumin 2.4 (Norm dated 6/13/11 identifies Respiratory and diabete 8/12/11 identifies Respiratory and the first obesity and diabete 8/12/11 identifies Respiratory and Table Inner thighs R (righ 1.0 x 1.2 x 0.2 exceindicate treatment Duoderm to left inno 7/29/11 at 1pm identifies the status documenting bigger in size 2.5 x continues on going dry and T&P (turn a (hours)." There is physician was noted obtained until 8/4/1 Sheet (POS) show 8/4/11 for Sanntyl a cleansing with norm needed) to the area The Treatment (TAR's) for July 20	ata Set (MDS) dated 7/28/11 a 69 year old female admitted a 1/11 with diagnoses of , Anxiety, Tracheostomy, I Fibrillation, Morbid Obesity, MDS indicates she is equires extensive to total es of Daily living (ADL's.). lated 7/6/11, R1 had a normal formal 5.5-8/3) and a low al 3.2-5.5). The care plan tifies her to be at risk for skin decreased mobility, morbid es. The care plan entry dated at to have three pressure e acquired on 7/24/11. ed dated 7/24/11 at 2pm int noted to have 2 areas on at 1.8cm x 1.2 x 0.2, L (left) corriation to thighs." The notes orders were received for ier thigh. Nurses notes dated intifies a decline in wound g "R inner thigh appears to be a.2.2 x 2" Resident and staff education for resident to be and reposition) q (every) 1-2 no documentation that the ied on 7/29/11 at the time the No new treatment orders were 1. The Physician's Order at a treatment change on and Silver Alginate after anal saline daily and PRN (as	F 22	24		

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F 224	only 5 days of the 8 7/31/11. The treatilateral leg which ide on the TAR for July On 8/15/11 at 1 identify a condition some lethargy with Percocet" and the ordered a reduction no vitals recorded evidence R1 was at than overmedication nurses also neglectoward the effective the next entry into The nurses note indicate R1's confurefusing medication brown and "wound (draining) foul sme reporting that resid is recorded as 100 Respirations 22 an physician was called the hospital emerging neglected to monitor pressure ulcers and possible causative monitor her body for According to ho PHYSICAL dated 8 emergency room will lower extremities. documentes R1 to right lower extremitiarea. According to areas were identified	B days from 7/24/11 through ment for the wound on the right entified as "unstageable" is not	F 25	24		

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F 253 SS=B	right groin area. Ar dated 8/25/11 implifever/sepsis." The Wound Note R1 to have a total cadmission varying sareas. On 9/29/11 at 1 stated R1 definitely hospital, and that sher admission on 8 fairness, he could rwounds on admissified the emergreport identified "midentifies two, one of her lower right leg. wound report that it wounds on dischard assessment and mwould be important was very familiar wonn-compliant with at times. Z3 stated emergency room repneumonologist, he services. Z3 stated being admitted, and their assessments. 483.15(h)(2) HOUS MAINTENANCE SI	on OPERATIVE REPORT res "Patient was admitted with red from the Hospital identify of 9 wounds present on retages from II's to necrotic ream, Z3 (R1's physician) red more wounds at the red had develop more following red from the had develop red from the Hospital Had developed the had develop red from the Hospital Had develop red from the Had develop red from the Had develop red from the Had develop red		224			11/4/11

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F 253 F 309 SS=G	by: Based on interview failed to provide an clean resident care comfortable, and sa residents (R4, R5, I Findings include: 1. On 9/7/11 during front lobby of the bodor that persisted was also noted on 9. 2. Odors were also on 9/7/11 through 9 which was sprayed 3. R4's bed was not poor condition with to her air mattress were medical tape. Interview with Z1, members), on 9/7/11 the rails and hose her ails and hose her ai	NT is not met as evidenced and observation, the facility odor free environment, and items necessary to maintain a anitary interior for 3 of 6 R6) in the sample of 6. It initial tour of the facility, the uilding had a pervasive foul throughout the day. This odor 19/8/11 and on 9/9/11. In identified throughout the day 19/9/11 on the Ventilator Unit frequently with air freshener. In the total throughout the day was observed to be taped with and Z2 (R4's family 11 at 10am, and both stated have been like that for a while wed the odors as well. CARE/SERVICES FOR	F 2				11/4/11

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F 309	by: Based on interview failed to identify/ass changes for 2 of 6 for change of condification failure resulted in Rafter exhibiting and and increased confiassessment or more admitted to the host Urinary tract infection cellulitis. Findings include: 1. The Minimum Didentifies R1 to be a to the facility on 5/3 Respiratory Failure Gastrostomy, Atrial and Anemia. The Malert/oriented and reassist of all Activities According to the (POS) for August 2 200mg every HS (but tabs every 6 hours Xanax 0.5mg every Tylenol 325mg 2 to pain/fever along with A psychiatric note of HS dose of Seroque There is no docureflecting the incread documentation regarders.	NT is not met as evidenced and record review, the facility sess and monitor conditions residents (R1, R4) reviewed from in the sample of 6. This residents (R1, R4) reviewed from in the sample of 6. This residents (R1, R4) reviewed from in the sample of 6. This residents to the hospital relevated temperature, lethargy fusion for two days with no nitoring being done. R1 was pital with fever, Sepsis, on, and Pressure ulcer with as 69 year old female admitted resident from the first of	F 309			

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F 309	developed 3 in-hou and orders received no further entries in when the notes dood ulcers were noted to no 8/4/11 when and debriding agent was ulcers. Between 7/notations in the nur Seroquel increase of At 12:15pm on 8 notified of pts (paties confusion possibly (reduced) to 1 tabes on the entry of although the PRN reseived the P8/8/11 and 8/10, two no 8/11 or 8/12 and 8/15/11. The MAR receive Xanax 0.5n 8/15 with an addition 8/10/11. There is no 8/15/11 or 8/16/11 condition change. There is no evid R1's increased con the entry on 8/15/11 when the nurses no document "skin coloconfused, refuses the meds, urine dark by (bilateral) (lower) less the contraction of the entry of the color of t	ge 8 dated 7/24/11 indicate R1 se acquired pressure sores d for treatments There are the nurses notes until 7/29/11 sument that the pressure o be larger. The next entry is ew treatment order for a sordered for the pressure 29/11 and 8/4/11, there are no ses notes regarding either the or the pressure ulcer. 8/15/11, the notes states "Dr ents) lethargy et some related to Percocet. Dose every 6 hours PRN." The include any assessment for ther than the Percocet medication administration gust 2011 documents that R1 ercocet 1 time on 8/3/11, ice on 8/4, 8/5/ and 8/9, none d only one time from 8/13 - documented that R1 did ng daily from 8/3/11 through nal dose given on 8/8/11 and no vital signs documented for following this identified ence the nurses monitored fusion, lethargy/fever following 1 until 8/17/11, two days later of the pressure of the pressure the pressure that R1 did ng daily from 8/3/11 through nal dose given on 8/8/11 and no vital signs documented for following this identified ence the nurses monitored fusion, lethargy/fever following 1 until 8/17/11, two days later of pale, res (resident) o eat or drink, refuses to take fown, wounds to bilat gs drgn (draining) foul smelly the pressure that the pressure that the pressure that the pressure the nurses monitored fusion, lethargy/fever following funtil 8/17/11 at 9:30 am for pale, res (resident) of the pressure that the pressure that the pressure the nurses monitored fusion, lethargy/fever following funtil 8/17/11, two days later the pressure that the pressur	F	309			

AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 309	the time of transfer consciousness cha dark amber, wound (times) 2 this am, p 100.1 degrees, puls blood pressure 122 Z3, R1's Physicisent to the emerger diagnosed with urin Decubitus ulcer with According to the Faconditus ulcer with Indicase a resident simmediately notify the personnel." and "Aflicensed personnel immediately" with vichief complaint, etc indicate that the not individuals will be directed with status of the cord with status of the cord with status of the MDS dated year old female adriant 11/14/05 with diagn Encephalopathy, Game Tracheostomy and The MDS indicates staff for all activities non-verbal and seven The care plan dated	cates nursing assessment at documents R1 in a level of nge, not eating recently, urine s getting worse, emesis x ale" Vital signs recorded at se 88, respirations 22 and /68. an, was notified and R1 was ncy room where she was ary tract infection, sepsis, and n surrounding cellulitis. cility Policy and Procedure on IGE, "any staff member who tatus change shall he appropriate licensed ter assessing the resident, the shall contact the physician ital signs, signs/symptoms of a The policy continues to diffication of the appropriate ocumented in the medical changes reflected on the 24 dowed for 72 hours. The 24 hour report does not tion in the medical record." 8/24/11 identifies R4 is a 23 mitted to the facility on oses of Sepsis, astrostomy Tube, Profound Mental Retardation. R4 is totally dependent on of Daily Living (ADL's), is erely cognitively impaired. It is doubt a dependent on a for all ADL's due to brain	F	608			

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F 309	According to the an order for Levaquand Cortisporin ear three times daily for implemented. Their documentation of we exhibiting prior to the Nurses notes from to reflect any symposany, prior to the medications are do TRACKING sheet as was initiated on 8/2 as to what signs/sy prior to the call to the The first entry documentation of the call to the temperature is nursing intervention ear drainage. There whether R4 had draw according to R4 on 9/7/11 at 10am, drainage from here was ordered on 8/2 also state R4's fact stated R4 has frequindication in the clirithese symptoms dealthough the physican antibiotic was ordered on The ANTIBIOTIC temperatures from	POS for August 2011, R4 had ain 500mg every day for 5 days of the grant of the gran	F	309			

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F 309 F 312 SS=D	S/S has "Drainage" fails to include the a and/or odor is any onotes dated 9/1/11 identifies R4 to hav drainage noted." Owrote "slight drainage notes dated 9/2/11 indicate a "small an noted on outer ear dated 9/3/11 also d to include any addit the physician was a drops were continue to why. The antibiotic tratemperature from 9 drainage identified (7am-7pm) and 9/8 evident after 9/8/11 having some draina 483.25(a)(3) ADL ODEPENDENT RES A resident who is undaily living receives maintain good nutri and oral hygiene. This REQUIREMENT by: Based on interview review, the facility faincontinent care for	Written in for R4's left ear but amount of drainage, color was present. The nurses (no time documented) e "scant amount of purulent on 9/2/11 7am to 7pm shift ge L (left) ear." and the nurses (no time recorded) again nount of purulent drainage canal." The tracking report ocumented drainage but fails cional information. On 9/4/11, again contacted and R4's ear ed with no documentation as acking sheets documents R4's 1/4/11 until 9/8/11 with as being "very little" on 9/6/11 1/11. There is no follow up even though R4 was still age from her left ear.	F 312			11/4/11

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F 312	Findings include: 1. The Minimum I identifies R4 is a 2 the facility on 11/12 Encephalopathy, O Tracheostomy and The MDS indicates staff for all activities "always incontinent According to her crisk for skin breakd and incontinence would be a considered for incontinent and dry after every On 9/7/11 at 10 observed to have a and stuffed between The towel was total the paper pad that was wet to all corn E4, Certified Nurse 10:40am, and E4 is breakfast. Z1 (R4's present in the room both stated they ar staff had been in the in bed with fam no staff had been in they arrived at 9:00 9/8/11. On 9/8/11 and changed as he was laying on was	Data Set (MDS) dated 8/24/11 3 year old female admitted to 4/05 with diagnoses of Sepsis, Gastrostomy Tube, I Profound Mental Retardation. Is R4 is totally dependent on It of bladder and bowel." I are plan dated 8/24/11, R4 is at down due to decreased mobility with interventions for staff to nence every 2 hours and clean of episode." Interview with urine as was was under her. The paper pad ers with urine. Interview with es Aide (CNA), on 9/7/11 at said that R4 had changed after is family), and Z2 (R4's family) in on 9/7/11 at 10:40am, and rived to visit R4 at 9am and no of check/change either resident whey arrived. Interview on at 12:30pm, R1 was again noted to ily at bedside. Z1 and Z2 stated in to check/change R1 since I and I was checked in to check/change with urine. I no staff had been in since they	F 312			

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	PROVIDER OR SUPPLIER	LEVILLE		40	REET ADDRESS, CITY, STATE, ZIP CODE O NORTH 64TH STREET BELLEVILLE, IL 62223			
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F 312	On 9/8/11, E2, E agreed that using a was inappropriate. responsible for R1 her a bedbath at 9:3 interviews of Z1and throughout the mor 2. According to the year old female adr with diagnoses of E Tracheostomy, Gas Respiratory Failure indicates R5 is total ADL's and is always bladder. The Care her to be at risk for decreased mobility interventions documented and dry, check hours and clean/dry others. The care propressure ulcers at the On 9/7/11 at 100 the head of the bed they arrived at 9am been in to check/ch room since they arrived at 9am bed rail. R5 was not incontinent pads un incontinent of urine mid thighs. The ou had began to dry le noted to have deep	Director of Nursing (DON), towel as an incontinent pad E2 also stated staff that morning reported giving 30am. This conflicts with Z2, and observations done ning. Admission Sheet, R5 is a 48 mitted to the facility on 12/7/06 down's Syndrome, strostomy Tube, and The MDS dated 6/21/11 dependent on staff for all is incontinent of bowel and incontinent of bowel and incontinence. The nent staff are to keep her skin like for incontinence every 2 after every episode among an indicates she has no his time. In R5 was laying in bed with elevated. Z1, and Z2 stated on 9/7/11, and no staff has ange either resident in the ived. R5 was observed in the 1:20am, 11am, and at was noted to be resting on the oted to have two cloth der her. R5 had been which went from her waist to the edge of the wet section aving a brown circle. R5 was red creases throughout both er thighs and back but no	F3	312				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145289	B. WIN	IG			C 5/2011
	ROVIDER OR SUPPLIER	LEVILLE		40	ET ADDRESS, CITY, STATE, ZIP CODE NORTH 64TH STREET ELLEVILLE, IL 62223	10/0	0/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPRICED TO THE APPRICED T	ULD BE	(X5) COMPLETION DATE
F 312 F 314 SS=G	observations that n check/change R5 s 483.25(c) TREATM	oo staff had come in to since 9am on 9/7/11.		312			11/4/11
	resident, the facility who enters the faci does not develop p individual's clinical they were unavoida pressure sores rec	orehensive assessment of a must ensure that a resident lity without pressure sores bressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and the healing, prevent infection and from developing.					
	by: Based on interview review, the facility fand provide prever residents (R1, R4, ulcer treatment and This failure resulted the physician for a	NT is not met as evidenced v, observation, and record failed to identify, assess, treat stative measures for 4 of 4 R5, R6) reviewed for pressure d prevention in the sample of 6. If in a 6 day delay in notifying treatment change when R1's identified to be bigger and ed drainage.					
	Findings include:						
	identifies R1 to be to the facility on 5/3 Respiratory Failure Gastrostomy, Atria and Anemia. The lalert/oriented and r	pata Set (MDS) dated 7/28/11 a 69 year old female admitted B1/11 with diagnoses of y, Anxiety, Tracheostomy, I Fibrillation, Morbid Obesity, MDS indicates she is requires extensive to total res of Daily living (ADL's.).					

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145289	B. WIN	IG		C 10/05/2011	
	PROVIDER OR SUPPLIER EALTHCARE OF BEL	LEVILLE	•	40	REET ADDRESS, CITY, STATE, ZIP CODE O NORTH 64TH STREET BELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	According to labs de Total Protein 5.7 (Nalbumin 2.4 (Normadated 6/13/11 identifies Resident and staff for resident and staff for resident and staff for resident to be dereposition) q (every documentation in the was notified of the The only other dis on the weekly Sk PRESSURE SORE on the thighs as staright lateral leg note "unstageable" meadepth. The Treatment (TAR's) for July 20 ordered daily to R1 being done only 5 or 7/24/11 through 7/3 lateral leg identified TAR for July 2011 as staright 2	ated 7/6/11, R1 had a normal lormal 5.5-8/3) and a low al 3.2-5.5). The care plan iffies her to be at risk for skin decreased mobility, morbid as. The care plan entry dated 1 to have three pressure acquired on 7/24/11. Addated 7/24/11 at 2pm at noted to have 2 areas on at 1.8cm x 1.2 x 0.2, L (left) oriation to thighs." The notes are received for Duoderm to left her thigh "santyl and DD (dry ext entry into the nurses notes are sores is on 7/29/11 at a sis "are to R inner thigh are in size 2.5 x 2.2 x 2" continues on going education and T&P (turn and 1) 1-2 (hours)." There is no ne nurses notes the physician wound deteriorating. Adocumentation of the wounds also on 7/24/11 as an area on the end also on 7/24/	F	314			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145289	B. WIN			C 10/05/2011	
	PROVIDER OR SUPPLIER EALTHCARE OF BEL	LEVILLE		40	REET ADDRESS, CITY, STATE, ZIP CODE O NORTH 64TH STREET BELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	includes an order dicatheter until wound documented in the On 8/4/11, the Atreatment change to and Silver Alginate saline daily, and PF the decline was done at the mext entry in 8/15/11 at 9am, and were attempting to in Wound Specialist the nurses notes id lethargy with some Percocet." No furth status toward effect is documented in the recorded. The next entry in 8/17/11. The nurse 9:30am indicate R1 with refusing medic dark brown and the drng (draining) foul reporting that residing recorded as 100 called, and R1 was emergency room. documentation of the since 8/15/11. According to hot PHYSICAL dated 8 emergency room will lower extremities. documents R1 to hight lower extremitiarea. "For details, particular and since a parti	ated 7/31/11 to insert a urinary ds are healed, but is not	F	314			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		145289	B. WIN				C 5/2011
	ROVIDER OR SUPPLIER EALTHCARE OF BEL	LEVILLE	•	40	REET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 64TH STREET BELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	cellulitis." Accordin areas were identified left lower extremity, right groin area. And dated 8/25/11 implified fever/sepsis. Patient ulcers. The ulcers wincluding one with the for debridement." The facility's doctonsistently documitime of discharge to failed to adequately stages the wounds. On 8/22/11, mean by the hospital on a wounds on admissing 1.4cm x 1/1cm pink 2cm x 1cm scabby pink/yellow tissue, wound 4cm x 3.5cm 1.5cm yellow tissue, wound 4cm x 3.5cm 1.5cm yellow tissue with depth of 0.25cm lateral calf 10cm x 9.5% grey tissue unsing 3.5cm (entire wound tissue noted some proposed for the wounds). Right thigh medial wyellow/green slough 7) Right thigh most pink moist with yellow 8)Right lower thigh tissue noted pink grounds.	itus ulcer with surrounding g to the wound care pictures, d on R1's buttocks, right calf, right groin (underneath) and a OPERATIVE REPORT es "Patient was admitted with at has multiple lower extremity were of varying stages, black eschar, indicating need umentation failed to ent all areas present at the o the emergency room and identify the status including	F	314			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		145289	B. WING _			C 5/2011
	PROVIDER OR SUPPLIER EALTHCARE OF BEL	LEVILLE	4	REET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 64TH STREET BELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	very non-compliant and did not like staf R1's wounds did ge wound consult, but documentation bes weekly report dated the facility before the E2 acknowledged at to include any refer care. E2 also state nurse until just rece walked out, and did suspects the wound with her. On 10/4/1 had no other wound On 9/9/11 at 1:1 Nurse (LPN), said hR1's wound in the wand stated she wou care at times. E5 sometimes 3-4 time incontinence, but the during the week wit weekend. E5 stated catheter order due keeping the dressin and urinary cathete pressure ulcer prevalent sheet through 8/17/11 for wound treatments with no PRN's document on 9/9/11 at 1pn (CNA), stated she catheter refused catheter refused catheter refused catheter refused catheter refused catheter or sheet resure ulcer prevalent sheet through 8/17/11 for wound treatments the with no PRN's document of the prevalent sheet catheter refused catheter refu	and E2 stated that R1 was with turning and repositioning of cleaning her up. E2 stated at worse, they had gotten a stated she had no other ides the nurses notes and 18/12/11. E2 stated R1 left are wound specialist saw her. Also that the Care Plan failed ence to her non-compliance to defend the facility had a wound ently, but the wound nurse of the facility had a wound ently, but the wound nurse of the facility had a wound ently, but the wound nurse of the facility had a wound ently, but the wound nurse of the facility had a wound ently, but the wound nurse she down the facility had a wound ently, but the wound nurse of the had done treatments on weeks prior to R1's discharge of the had done treatments on weeks prior to R1's discharge of the had done treatments on weeks prior to R1's treatments are per shift due to the facility got a urinary to R1's wound and difficulty of the facility got a urinary to R1's wound and difficulty of the facility got a urinary to R1's refusal of care or is not incorporated into the ention plan. The fam shift document the peing done only one time daily mented as E5 indicated. The facility R1 frequently, that are, and was very difficult to estated R1 was frequently	F 314			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145289	B. WIN			C 10/05/2011	
	ROVIDER OR SUPPLIER	LEVILLE	•	40	REET ADDRESS, CITY, STATE, ZIP CODE O NORTH 64TH STREET BELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	On 9/29/11 at 1's stated R1 definitely hospital, and that si following her admis "all fairness, he couwounds on admissi identified." Z3 agreemonitoring with docimportant in wound familiar with R1, that with care, and could stated he did not loreports, and being a patients to wound on R1's morbid obesity but did acknowledg been monitoring he to her non-complian Z3 stated he had refound that they doconly identified 2 in the and the other on he know why they wouthree as the facility review the pictures present "on admission there was a "lag time admitted and the was a "lag time admitted and the was a "lag time admitted and the was a license problems to a license evident since R1 was room with more present was a with more present was not allow the problems to a license evident since R1 was room with more present was not allow the problems to a license evident since R1 was room with more present was not allow the problems to a license evident since R1 was room with more present.	ge 19 Itam, Z3 (R1's physician) had more wounds at the he had developed more sion on 8/17/11. Z3 stated in ald not say there weren't added on than what the facility had bed that assessment and rumentation would be care. Z3 stated he was very at she was very non-compliant d be demanding at times. Z3 ok at the emergency room a pneumonologist, he refers har services. Z3 agreed that a was a main point of concern, he that the facility should have ar skin for additional sores due here. On 10/6/11 at 9:40am, here were the emergency notes, here in the the emergency notes, here in the the emergency notes, here in the the thought he note; one by the catheter her right lower leg. Z3 did not he note; one by the catheter her right lower leg. Z3 did not he areas identified at least had. Z3 stated he did not hof the 9 areas identified as had. Z3 stated he thought he between when she was hound care assessment." A SKIN AND WOUND CARE CEDURE, it is the policy of hide appropriate skin care to he skin integrity. The policy her or end of the emergency has not as admitted to the emergency has not as a distinct the emergency has not as a distinct the emergency has not as a distinct to the emergency has not as a distinct t	F	314			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		145289	B. WIN	G			5/ 2011
	PROVIDER OR SUPPLIER	LEVILLE	•	40	EET ADDRESS, CITY, STATE, ZIP CODE) NORTH 64TH STREET ELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	will be documented sheet and placed o week. "Wound care on the back of the record) each week. this policy as the or wounds identified by 7/29/11, but none didentified the wound deteriorating. The interdisciplinary tead discuss wounds, st breakdown but no document that R1's needed. 2. The MDS dated year old female adr 11/14/05 with diagr Encephalopathy, G Tracheostomy and The MDS indicates staff for all activities "always incontinent According to her carisk for skin breakd and incontinence w "Check for incontinand dry after every repositioning per fa On 9/7/11 at 10: observed to have a and stuffed betwee The towel was total the paper pad that was wet to all corne E4, Certified Nurse	on a wound assessment flow in the wound report each erelated notes will be written TAR (treatment administration." The facility failed to follow ally documentation of the yethe facility is initially, then on locumented when the nurses do as a odorous and policy also indicates weekly in meetings will be held to atus, treatment and further documentation was provided to a wounds were assessed as 8/24/11 identifies R4 is a 23 mitted to the facility on loses of Sepsis,	F3	14			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145289	B. WING			C 95/2011
	PROVIDER OR SUPPLIER	LEVILLE	40	EET ADDRESS, CITY, STATE, ZIP CODE O NORTH 64TH STREET ELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	present in the room both stated they aristaff had been in to in the room since the On 9/8/11 at 10:2 be in bed with family no staff had been in they arrived at 9:00 9/8/11. On 9/8/11 and changed as he was laying on was and Z2 stated that arrived at 9:00 am On 9/8/11 during Director of Nursing responsible for R1 R1 a bed bath at 9: with interview of Z1 done at the time. On 9/8/11 and change in reposition until 12:30 pm on 9/8/11 and female addivith diagnoses of Experimental Tracheostomy, Gas Respiratory Failure indicates R5 is tota ADL's and is alway bladder. The Carher to be at risk for decreased mobility interventions docur reposition her accokeep her skin clear incontinence every	family), and Z2 (R4's family) on 9/7/11 at 10:40am, and rived to visit R4 at 9am and no check/change either resident ney arrived. 20am, R1 was again noted to by at bedside. Z1 and Z2 stated in to check/change R1 since am when they arrived on at 12:30pm, R1 was checked in incontinent pad which she entirely soaked with urine. Z1 no staff had been in since they on 9/8/11. I the daily meeting, E2, (DON) stated staff that morning reported giving 30am. However, this conflicts and Z2, and observations observations done show no ning at least from 10:20am (8/11.)	F 314			

Facility ID: IL6006704

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		145289	B. WING _				
	PROVIDER OR SUPPLIER	LEVILLE	4	REET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 64TH STREET BELLEVILLE, IL 62223			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 314	pressure ulcers at to On 9/7/11 at 10a the head of the beat they arrived at 9am been in to check/chroom since they arrived at 9am same position at 10 11:30am, her head bed rail. R5 was no incontinent of urine mid thighs. The outhad began to dry le noted to have deep buttocks, hips, uppopen areas. Z1, an had come in to che since they arrived a According to the AND POSITIONING not currently have srepositioned at least 4. R6's Care Plan has pressure ulcers Interventions indicare reposition per facility checks, monitor sk changes to nurses, ordered. The POS treatments to the hococyx/sacrum ord saline, apply Santyl as needed. Monito Plan identifies the salice was a second to the salice was a	Plan indicates she has no this time. am, R5 was laying in bed with a elevated. Z1, and Z2 stated on 9/7/11, and no staff has hange either resident in the rived. R5 was observed in the 2:20am, 11am, and at was noted to be resting on the oted to have two cloth hader her. R5 had been which went from her waist to ter edge of the wet section aving a brown circle. R5 was ored creases throughout both her thighs and back but no d Z2 confirmed that no staff ck/change and reposition R5 at 9am 9/7/11. facility's policy on TURNING G, all bedfast residents that do skin breakdown will be st every 2 hours. dated 8/25/11 documents he is on his coccyx and left heal. It is staff are to turn and the staff are to turn and the policy, do weekly skin in during care and report provide treatments as documents an order for eels and coccyx/sacrum. The er is to cleanse with normal and Silver Alginate daily and r for effectiveness. The Care sacrum wound as measuring	F 314				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDIN	G	,	C
	145289	B. WING			5/2011
NAME OF PROVIDER OR SUPPLIER HELIA HEALTHCARE OF BEL	LEVILLE	4	REET ADDRESS, CITY, STATE, ZIP CODE O NORTH 64TH STREET BELLEVILLE, IL 62223		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
to his right side to of the wound packing sore as he was turn dressing present or no dressing in the bappeared to have a some odor. According to the observation, R6's tracknowledged that of the dressing present of the dre	poserved in bed. He was rolled observe his treatment site, and fell out of his gaping pressure ned over. There was no wer the packing, and there was ped cloths. His wound a large amount of drainage with the reatment is done daily. E15 the packing was the only part sent on the area. It's MDS dated 8/18/11, he is one staff for bed mobility and all other activities of daily lso indicates he has a urinary estomy. R6 diagnoses include a sacrum pressure ulcer. Formation identifies R6 to be a dimitted on 8/11/11. EASE/PREVENT DECREASE TION TION To rehensive assessment of a must ensure that a resident and services to increase d/or to prevent further of motion. NT is not met as evidenced w, observation, and record ailed to provide adequate range of motion, appropriate	F 314			11/4/11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145289	B. WI			C 10/05/2011	
	ROVIDER OR SUPPLIER	LEVILLE		40	EET ADDRESS, CITY, STATE, ZIP CODE O NORTH 64TH STREET ELLEVILLE, IL 62223	10/00	0/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 318	reviewed for passive the sample of 6. Findings include: 1. The Minimum Date identifies R4 is a 23 the facility on 11/14 Encephalopathy, Garacheostomy and The MDS indicates staff for all activities MDS also identifies limitations identified but recieves no PROS heet (POS) for Se orders on it nor doe program/plan to address on the seven extremeties includir Interview of Z1 (R4' on 9/7/11 at 9:55 and R4 has wash clothed she doesn't. Z1 and whether R4 was recontractures, or not PROM's done. Z1 in the chair very infin positioning due to have the same province of the same province in the chair very infin positioning due to have the same province of the sam	reatment of current of 2 residents (R4, R5) of 2 residents (R4) of 3 residents (R5) of 3 residents (R4) of	F	318			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION _DING		(X3) DATE SURVEY COMPLETED	
		145289	B. WIN	G	10/0	C)5/2011	
	ROVIDER OR SUPPLIER	LLEVILLE		STREET ADDRESS, CITY, STATE, ZIP C 40 NORTH 64TH STREET BELLEVILLE, IL 62223	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 318	and monthly notes identify R4's limited program plan to ac Plan also fails to ic contractures and the On 9/8/11, E2, receives PROM's of On 9/8/11 at 3pm, (CNA), identified R does range of mothor On 9/9/11 at 1:4 stated preferably radone twice daily 7 you move them, the stated she does not facility on ROM, but only way to measure or decline. The facility's positive months are alled to follow range of motion not appropriately.	ssments including quarterly toward R4's contractures that ions, and that include a dress these needs. The Care lentify R4's current ne need for services. Director of Nursing, said R4 one time daily on second shift. E12, Certified Nurses Aide 4 as one of two residents she ion on. 40pm, E13, Physical Therapist, ange of motion exercises are days a week, and "the more e better off you are." E13 of do any measurements for the at agreed that it would be the re maintenance, improvement, licy entitled RANGE OF adicates exercises will be not in need of exercises as are Plan, in order to maintain, further decline. The facility it's policy to ensure that R4's ends are met consistently and	F3	318			
	year old female ad with diagnoses of I Tracheostomy, Ga Respiratory Failure indicates R5 is tota ADL's and has ran extremeties for wh	e Admission Sheet, R5 is a 48 mitted to the facility on 12/7/06 Down's Syndrome, strostomy Tube, and e. The MDS dated 6/21/11 ally dependent on staff for all ge of motion limitations all four ich she receives PROMs. The is on bedrest. The Care Plan					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145289	B. WIN	NG		C 10/05/2011	
	ROVIDER OR SUPPLIER	LEVILLE	•	40	EET ADDRESS, CITY, STATE, ZIP CODE D NORTH 64TH STREET ELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPRINCE O	ULD BE	(X5) COMPLETION DATE
F 318	identifies PROMs a but doesn't indicate are. On 9/8/11 at 3 perform range of m hands were held tig to have contractute including severe for three repititions on hand and wrist, ran range of motion on about R5's hands, a something in them. didn't have anything R5's right hand was looking skin in the pwas noted to have an ails dug into her p R5's legs and failed aspects of her kneed difficult to do due to R5 was observed to have anothing in her hand digging into her pal.	s an intervention done daily to what extent her limitations pm, E12, CNA, was asked to otion exercises on R5. R5's phtly in a fist and R5 was noted s of all four extremeties of drop bilaterally. E12 did R5's shoulder, rotated her ged her fingers, but did not do her elbow. E12 was asked and whether they usually put E12 stated yes, although R5 g in either hand at the time. Is observed to have white moist oalm area, and her left hand small open areas where her alm. E12 continued to range if to range her toes and all es. E12 did state R5 was on her contractures. Wed on 9/7/11 at 10am to have so to prevent her nails from ms.	F3	318			
	MOVEMENT/ROM which documented from10/13/10 throu R5 had limitations odid not provide any towards limitations.	ASSESSMENT was provided quarterly reviews from gh 6/21/11 identifying only that on both sides of the body. E2 additional assessments					
		olicy on Range of Motion hat all joints will be ranged,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	G		C
		145289	B. WING _			5/ 2011
	ROVIDER OR SUPPLIER EALTHCARE OF BEL	LEVILLE	4	REET ADDRESS, CITY, STATE, ZIP CODE O NORTH 64TH STREET BELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 318 F9999	Continued From pa and repetitions will FINAL OBSERVAT LICENSURE VIOL	be between 5 and 10 times. IONS	F 318 F9999			
	300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3240a)	oridant Caro Deligios				
	a) The facility shall procedures, govern the facility which sh Resident Care Polic least the administrathe medical advisor representatives of reference the facility. These pwith the Act and all These written polici operating the facility least annually by the	have written policies and ing all services provided by all be formulated by a cy Committee consisting of at utor, the advisory physician or y committee and nursing and other services in olicies shall be in compliance rules promulgated thereunder. es shall be followed in y and shall be reviewed at is committee, as evidenced by dated minutes of such a				
	h) The facility shall of any accident, injuresident's condition safety or welfare of limited to, the prese decubitus ulcers or percent or more wit	Medical Care Policies notify the resident's physician ary, or significant change in a that threatens the health, a resident, including, but not ence of incipient or manifest a weight loss or gain of five hin a period of 30 days. The and record the physician's plan				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		145289	B. WIN	IG _		C 10/05/2011	
	ROVIDER OR SUPPLIER EALTHCARE OF BEL	LEVILLE	•	40	REET ADDRESS, CITY, STATE, ZIP CODE O NORTH 64TH STREET BELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	of care for the care injury or change in notification. Section 300.1210 © Nursing and Person b) The facility shall and services to attate practicable physical well-being of the releash resident's complan. Adequate and care and personal care and personal cresident to meet the care needs of the releash resident's condition emotional changes determining care refurther medical evaluate made by nursing stresident's medical resident's medical resident	or treatment of such accident, condition at the time of General Requirements for all Care provide the necessary care in or maintain the highest I, mental, and psychological sident, in accordance with aprehensive resident care I properly supervised nursing care shall be provided to each e total nursing and personal esident. Ervations of changes in a including mental and in as a means for analyzing and equired and the need for luation and treatment shall be aff and recorded in the record	F99	999	DEFICIENCY)		
	Based on interview failed to identify/ass changes for 2 of 6 for change of condi	are not met as evidenced by: and record review, the facility sess and monitor condition residents (R1, R4) reviewed ton in the sample of 6. This 1 being transfer to the hospital					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		145289	B. WIN	NG _			C 5/2011	
	ROVIDER OR SUPPLIER	LEVILLE	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 64TH STREET BELLEVILLE, IL 62223			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F9999	and increased conf assessment or mor admitted to the hos Urinary tract infection cellulitis. Findings include: 1. The Minimum Didentifies R1 to be at to the facility on 5/3 Respiratory Failure Gastrostomy, Atrial and Anemia. The Malert/oriented and reassist of all Activities According to the Prorect for August 2011, Revery HS (bedtime) every 6 hours as no 0.5mg every 4 hours 325mg 2 tabs every along with other roupsychiatric note dat dose of Seroquel where the service of the provided commentation regard new dose, and/or pwith the change. The nurse notes dat developed 3 in-hou and orders received.	ge 29 elevated temperature, lethargy usion for two days with no nitoring being done. R1 was pital with fever, Sepsis, on, and Pressure ulcer with at Set (MDS) dated 7/28/11 at 69 year old female admitted 1/11 with diagnoses of Anxiety, Tracheostomy, Fibrillation, Morbid Obesity, MDS indicates she is equires extensive to total as of Daily living (ADL's.). Pysician's Order Sheet (POS) 1 received Seroquel 200mg, Percocet 5/325mg 2 tabs are ded (PRN) for pain, Xanax as PRN for anxiety, Tylenol at 4 hours PRN for pain/fever at the medications. A ded 7/24/11 documents her HS as increased to 300mg. Pentation in the nurses notes are in Seroquel, and no arding the effectiveness of the ossible adverse side effects at documents. There are the nurses notes until 7/29/11	F99	999				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		145289	B. WII	۱G _			C 5/2011	
	ROVIDER OR SUPPLIER EALTHCARE OF BEL	LEVILLE	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 64TH STREET BELLEVILLE, IL 62223			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F9999	ulcers were noted to on 8/4/11 when a note of the desired agent was ulcers. Between 7/ notations in the nurse of the desired at 12:15pm on 8/15 notified of pts (paties confusion possibly (reduced) to 1 tabes of the desired at 12:15pm on 8/15 on the desired according to 2 table and 2 table and 3 table and	sument that the pressure to be larger. The next entry is ew treatment order for a sordered for the pressure 29/11 and 8/4/11, there are no sees notes regarding either the pressure ulcer. 6/11, the notes states, "Dreats) lethargy et some related to Percocet. Dose every 6 hours PRN." The include any assessment for ther than the Percocet nedication administration gust 2011 documents that R1 ercocet 1 time on 8/3/11, ice on 8/4, 8/5 and 8/9, none only one time from 8/13 - documented that R1 did ng daily from 8/3/11 through nal dose given on 8/8/11 and o vital signs documented for following this identified see the nurses monitored R1's n, lethargy/fever following the til 8/17/11, two days later	F9:	999				
	document "skin cold confused, refuses t meds, urine dark br (bilateral) (lower) le dark drng. staff stat Transfer sheet indic the time of transfer	otes dated 8/17/11 at 9:30am or pale, res (resident) or eat or drink, refuses to take rown, wounds to bilat gs drgn (draining) foul smelly es res not herself." The cates nursing assessment at documents R1 in a level of nge, not eating recently, urine						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		145289	B. WING		 C 10/05/2011	
	ROVIDER OR SUPPLIER	LEVILLE		STREET ADDRESS, CITY, STATE, ZI 40 NORTH 64TH STREET BELLEVILLE, IL 62223	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F9999	(times) 2 this am, p 100.1 degrees, pul blood pressure 122 Z3, R1's Physician to the emergency r diagnosed with urin Decubitus ulcer wit According to the Fa CONDITION CHAN notices a resident s immediately notify personnel." and "A licensed personnel immediately" with v chief complaint, etc indicate that the no individuals will be of record with status of hour report and foll "Documentation or replace documentation or	ds getting worse, emesis x bale" Vital signs recorded at see 88, respirations 22 and 2/68. It was notified and R1 was sent soom where she was hary tract infection, sepsis, and th surrounding cellulitis. It was recorded and R1 was sent soom where she was hary tract infection, sepsis, and th surrounding cellulitis. It was recorded and R1 was sent soom where she was hary tract infection, sepsis, and th surrounding cellulitis. It was recorded and R1 was sent soom where she was hard the sepsis, signs/symptoms of the shall contact the physician wital signs, signs/symptoms of the shall contact the physician wital signs, signs/symptoms of the shall contact the physician wital signs, signs/symptoms of the shall contact the physician wital signs, signs/symptoms of the appropriate documented in the medical changes reflected on the 24 lowed for 72 hours. It was recorded at the same was sent to the same wital signs, signs/symptoms of the same wital signs, sign	F99!	99		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		145289	B. WING			C 5/2011	
	ROVIDER OR SUPPLIER	LEVILLE	S	TREET ADDRESS, CITY, STATE, ZIP COD 40 NORTH 64TH STREET BELLEVILLE, IL 62223			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F9999	and Cortisporin ear three times daily for implemented. Ther documentation of wexhibiting prior to the Nurses notes from to reflect any symptom any, prior to the medications are do TRACKING sheet awas initiated on 8/2 as to what signs/symprior to the call to the The first entry docu 97.9 degrees with "under nursing intervention ear drainage. Ther whether R4 had draws ordered on 8/2 also state R4's facts stated R4 has frequindication in the clirithese symptoms dealthough the physican antibiotic was ordered.	gits (drops) ii (2) to Left ear 10 days written and 11 days written and 12 is no information and/or 13 what symptoms R4 was 14 e order being received. 15 which is being could have had, if dication being ordered. 16 which is being could have had, if dication being ordered. 17 which is being check temp, monitor 18 being check temp, monitor 19 is no indication as to a large amount of 19 is a was swollen as well. 19 is no incal record that R4 had any of iscribed by R4's mother ian was called by nursing and	F999	9			

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	NG	(C
		145289	B. WING _			5/2011
	ROVIDER OR SUPPLIER EALTHCARE OF BEL	LEVILLE	4	REET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 64TH STREET BELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	(Signs/symptoms)" infection/dry." On 9 S/S has "Drainage" fails to include the a and/or odor is any worten odor odor is any worten odor odor is any worten odor odor odor odor odor odor odor odo	"Infections related S/S	F9999			
	a) The facility shall	have written policies and ing all services provided by				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		145289	B. WI				C 5/2011	
	ROVIDER OR SUPPLIER	LEVILLE	'	4	REET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 64TH STREET BELLEVILLE, IL 62223			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F9999	Resident Care Polic least the administrathe medical advisor representatives of representa	all be formulated by a cy Committee consisting of at attor, the advisory physician or by committee and a committee and a committee and a committee and a compliance and a committee and a compliance and shall be followed in a committee, as evidenced by dated minutes of such a committee.	F99	999				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		145289	B. WII				C 5/2011
	ROVIDER OR SUPPLIER	LEVILLE	ı	4	REET ADDRESS, CITY, STATE, ZIP CODE O NORTH 64TH STREET BELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES OF THE AP	ULD BE	(X5) COMPLETION DATE
F9999	each resident's complan. Adequate and care and personal or resident to meet the care needs of the resident to meet the care needs of the resident of the resident bactomprehensive assumed goals to be accomprehensive assumed goals to be accomprehen	prehensive resident care properly supervised nursing care shall be provided to each e total nursing and personal esident. Supervision of Nursing up-to-date resident care plan ased on the resident's ressment, individual needs complished, physician's orders, and nursing needs. Personnel, services such as nursing, and such other modalities as physician, shall be involved in the resident care plan. The ing and shall be reviewed and with the care needed as ident's condition. The plan at least every three months and procedures shall be dered by the physician. Ervations of changes in a procedured and the need for luation and treatment shall be aff and recorded in the	F9	999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		TIPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	TED
		145289	B. WIN	NG _		C 10/05/2011	
	ROVIDER OR SUPPLIER			4	REET ADDRESS, CITY, STATE, ZIP CODE 40 NORTH 64TH STREET BELLEVILLE, IL 62223	10/0.	<i>3</i> /2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	enters the facility w develop pressure so clinical condition de sores were unavoid pressure sores sha services to promote and prevent new properties of a facility shaden of a facility fand provide preven residents (R1, R4, I ulcer treatment and This failure resulted the physician for a facility developed of the facility of the facility of the facility of the facility on 5/3 Respiratory Failure Gastrostomy, Atrial and Anemia. The Malert/oriented and reassist of all Activitie According to labs desired or the facility on 10 facility of 10 faci	ithout pressure sores does not ores unless the individual's emonstrates that the pressure lable. A resident having II receive treatment and e healing, prevent infection, essure sores from developing. Abuse and Neglect ee, administrator, employee or nall not abuse or neglect a ere not met as evidenced by: The observation, and record ailed to identify, assess, treat tative measures for 4 of 4 erest of the prevention in the sample of 6. If in a 6 day delay in notifying treatment change when R1's identified to be bigger and	F99	999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145289	B. WII	NG		C 10/05/2011	
	ROVIDER OR SUPPLIER	LEVILLE	•	40	EET ADDRESS, CITY, STATE, ZIP CODE) NORTH 64TH STREET ELLEVILLE, IL 62223		
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F9999	Albumin 2.4 (Normadated 6/13/11 identifies Reakdown due to cobesity and diabete 8/12/11 identifies Resolution wounds all in-house. The nurses noted of document, "Reside inner thighs R (right 1.0 x 1.2 x 0.2 excondicate treatment of Duoderm to left inn 7/29/11 at 1:00pm is status documenting bigger in size 2.5 x continues on going dry and T&P (turn a (hours)." There is rephysician was noted obtained until 8/4/1 Sheet (POS) shows 8/4/11 for Sanntyl acleansing with normal needed) to the area The only other documenting with the resolution of the weekly SKIN PRESSURE SORE on the thighs as staright lateral leg note "unstageable" meandepth. The Treatment Admits of Treatment Admits of July 2011 documents and displayed and the treatment Admits of July 2011 documents and the treatments	al 3.2-5.5). The care plan ifies her to be at risk for skin decreased mobility, morbid is. The care plan entry dated 1 to have three pressure acquired on 7/24/11. Idated 7/24/11 at 2:00pm int noted to have 2 areas on it) 1.8cm x 1.2 x 0.2, L (left) oriation to thighs." The notes orders were received for er thigh. Nurses notes dated dentify a decline in wound in the light in the led on 7/29/11 at the time the led on 3/29/11 at the	F9:	999			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SU COMPLE	
		145289	B. WI				C 5/2011
	ROVIDER OR SUPPLIER	LEVILLE	'	4	REET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 64TH STREET BELLEVILLE, IL 62223		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	5 days of the 8 days 7/31/11. The woun identified as "unstaguly 2011 at all for the Review of the Physincludes an order documented in the On 8/4/11, the Augitreatment change to and Silver Alginate saline daily, and PF the decline was documented in the decline was documented in the saline daily, and PF the decline was documented in the decline was documented in the nurses notes idlethargy with some Percocet." No furth status toward effect is documented in the recorded. The next entry into 8/17/11. The nurse 9:30am indicate R1 with refusing medic dark brown and the drng (draining) foul reporting that reside is recorded as 100. called, and R1 was emergency room.	s from 7/24/11 through d on the right lateral leg geable" is not on the TAR for creatments. ician's Order Sheet (POS) ated 7/31/11 to insert a urinary ds are healed, but is not	F99	999			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		145289	B. WIN	۱G		C 10/05/2011	
	ROVIDER OR SUPPLIER	LEVILLE	•	4	REET ADDRESS, CITY, STATE, ZIP CODE O NORTH 64TH STREET BELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDERSON CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	since 8/15/11. According to hospit dated 8/17/11, R1 proom with a large wextremities. Under R1 to have "multiple extremities" and als details, please see care note." The as a "Decubitus ulcer According to the wordentified on R1's bextremity, right groi area. An OPERAT implies "Patient was Patient has multiple ulcers were of varyiblack eschar, indicated the modern all areas discharge to the emadequately identify wounds were curre. On 8/22/11, measure the hospital on admissing 1.4cm x 1/1cm pink 2cm x 1cm scabby pink/yellow tissue, wound 4cm x 3.5cm 1.5cm yellow tissue with depth of 0.25c lateral calf 10cm x 5% grey tissue unsigned to the spital on the pink 2cm x 1cm scabby pink/yellow tissue, wound 4cm x 3.5cm 1.5cm yellow tissue with depth of 0.25c lateral calf 10cm x 5% grey tissue unsigned to hospital on the pink 2cm x 1cm scabby pink/yellow tissue, wound 4cm x 3.5cm 1.5cm yellow tissue with depth of 0.25c lateral calf 10cm x 5% grey tissue unsigned the pink 2cm x 1cm 2cm 2cm 2cm 2cm 2cm 2cm 2cm 2cm 2cm 2	al HISTORY AND PHYSICAL presented to the emergency yound on the right lower EXTREMITIES, it documents to wounds on the right lower to on the right groin area. "For the pictures from the wound sessment identifies the areas with surrounding cellulitis." bund care pictures, areas were uttocks, right calf, left lower in (underneath) and right groin IVE REPORT dated 8/25/11 and admitted with fever/sepsis. It is admitted with fever/sepsis. It is always including one with a lating need for debridement."	F99	999			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED				
		145289	B. WING			C 5/2011
	PROVIDER OR SUPPLIER	LEVILLE	S	TREET ADDRESS, CITY, STATE, ZIP COI 40 NORTH 64TH STREET BELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F9999	Right thigh medial of yellow/green slough 7) Right thigh most pink moist with yellow 8) Right lower thigh tissue noted pink growth tissue noted pink growth buttocks 2cm x 1cm 8/25/11, R1 underwoof the wounds. Interview of E2, Dir 9/8/11 at 11:25am, very non-compliant and did not like staft R1's wounds did growth growth documentation besweekly report dated the facility before the E2 acknowledged at the include any refercare. E2 also state nurse until just recewalked out, and did suspects the wound with her. On 10/4/1 had no other wound On 9/9/11 at 1:10pr Nurse (LPN), said R1's wound in the wand stated she would care at times. E5 sometimes 3-4 time incontinence, but the during the week with the state of the sound in the wand the week with the state of the work with the week with the week with the work with the week w	poink moist base noted. 6) wound 2.5cm x 2.5cm n issue over pink moist tissue medial posterior 6.5 x 8cm ow tissue noted 1.5cm depth. posterior 8cm x 5cm yellow ranulation noted 9) Right n and 1cm x .5cm. On rent surgery for debridement ector of Nursing (DON), on and E2 stated that R1 was with turning and repositioning of cleaning her up. E2 stated at worse, they had gotten a stated she had no other ides the nurses notes and 18/12/11. E2 stated R1 left the wound specialist saw her. also that the Care Plan failed tence to her non-compliance to d the facility had a wound ently, but the wound nurse n't return. E2 states she d nurse took documentation 1 at 2:16pm, E2 stated she d records to provide. The provide of the facility had a records to provide. The provide of the facility had a records to provide. The provide of the facility had a records to provide. The provide of the facility had a records to provide. The provide of the facility had a records to provide. The provide of the facility had a records to provide. The provide of the facility had a records to provide. The provide of the facility had a records to provide. The provide of the facility had a records to provide of the facility had a records to provide. The provide of the facility had a record of the f	F999	9		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SU COMPLE	
		145289	B. WI	NG			C 5/2011
	ROVIDER OR SUPPLIER	LEVILLE	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 64TH STREET BELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	keeping the dressin and urinary cathete pressure ulcer previous Treatment sheets in 8/17/11 for the 7 am treatments being do PRN's documented On 9/9/11 at 1 pm, If (CNA), stated sheed R1 often refused cadeal with. E4 also sincontinent of bower On 9/29/11 at 11 am R1 definitely had mand that she had deadmission on 8/17/he could not say the admission than what Z3 agreed that assed documentation wout Z3 stated he was very non-compited demanding at times the emergency room pneumonologist, he services. Z3 agree a main point of conthe facility should he for additional sores On 10/6/11 at 9:40 at the emergency noted documented multip in the note; one by the services on by the services one by the services of	to R1's wound and difficulty ag dry. R1's refusal of care is not incorporated into the ention plan. eviewed from 8/1/11 through a shift document the wound one only one time daily with no as E5 indicated. E4, Certified Nurses Aide cared for R1 frequently, that are, and was very difficult to stated R1 was frequently. I and bladder. A, Z3 (R1's physician) stated ore wounds at the hospital, eveloped more following her 11. Z3 stated in "all fairness, are weren't added wounds on at the facility had identified." essment and monitoring with all be important in wound care. Bery familiar with R1, that she will be important in wound care. Bery familiar with R1, that she will be important to wound care at the facility had identified at the facility had identified. The ery familiar with R1, that she will be important in wound care are refers patients to wound care at that R1's morbid obesity was cern, but did acknowledge that ave been monitoring her skin due to her non-compliance. E4, Certified Nurses Aide wound in the wound was required to a state of the same and was required to a state of the wound care at the facility had identified. The wound care are refers patients to wound care at the R1's morbid obesity was cern, but did acknowledge that ave been monitoring her skin due to her non-compliance. E4, Certified Nurses Aide wound with no as E5 indicated. E4, Certified Nurses Aide wound with no as E5 indicated. E4, Certified Nurses Aide wound with no as E5 indicated. E4, Certified Nurses Aide wound with no as E5 indicated. E4, Certified Nurses Aide wound with no as E5 indicated. E4, Certified Nurses Aide wound with no as E5 indicated. E4, Certified Nurses Aide wound with no as E5 indicated. E4, Certified Nurses Aide wound with no as E5 indicated. E4, Certified Nurses Aide wound with no as E5 indicated. E4, Certified Nurses Aide wound with no as E5 indicated. E5, Z3 (R1's physician) stated wounds on at the hospital with no as E5 indicated. E5, Z3 stated in "all fairness, with no as E5 indicated. E5, Z3 stat	F99	999			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SU COMPLE	
		145289	B. WI	۱G _			C 5/2011
	ROVIDER OR SUPPLIER	LEVILLE		4	REET ADDRESS, CITY, STATE, ZIP CODE IO NORTH 64TH STREET BELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	facility had. Z3 state pictures of the 9 are admission.", but state "lag time between with the wound care associated as a coording to the Sk POLICY AND PRO the facility's to provimaintain or improve indicate CNA's are problems to a license evident since R1 was room with more preat the facility. The pwill be documented sheet and placed of week. "Wound care on the back of the record) each week. this policy as the or wounds identified by 7/29/11, but none didentified the wound identified the wound deteriorating. The pinterdisciplinary tead discuss wounds, stabreakdown but no coordinate that R1's needed. 2. The MDS dated year old female adri 11/14/05 with diagn Encephalopathy, G. Tracheostomy and	ified at least three as the ed he did not review the eas identified as present "on ated he thought there was a when she was admitted and ressment." KIN AND WOUND CARE CEDURE, it is the policy of ide appropriate skin care to east integrity. The policy to report new skin care see nurse. This was not as admitted to the emergency resure ulcers that documented policy also indicates wounds on a wound assessment flow in the wound report each erelated notes will be written TAR (treatment administration). The facility failed to follow ally documentation of the yether facility is initially, then on occumented when the nurses dis as odorous and policy also indicates weekly in meetings will be held to eatus, treatment and further documentation was provided to wounds were assessed as 8/24/11 identifies R4 is a 23 initied to the facility on oses of Sepsis,	F99	999			

Facility ID: IL6006704

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPLE	
		145289	B. WING	<u> </u>		C 5/2011
	PROVIDER OR SUPPLIER	LEVILLE	S	STREET ADDRESS, CITY, STATE, ZIP 40 NORTH 64TH STREET BELLEVILLE, IL 62223	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ΓΙΟΝ SHOULD BE ΓΗΕ APPROPRIATE	(X5) COMPLETION DATE
F9999	"always incontinent According to her carisk for skin breakd and incontinence w "Check for incontine and dry after every repositioning per fa On 9/7/11 at 10:40a observed to have a and stuffed betwee The towel was total the paper pad that was wet to all corne E4, Certified Nurse: 10:40am, and E4 sibreakfast. Z1 (R4's present in the room both stated they arr staff had been in to in the room since the On 9/8/11 at 10:20a in bed with family a staff had been in to arrived at 9:00am w On 9/8/11 at 12:30g changed as her inclaying on was entire Z2 stated that no starrived at 9:00am on 9/8/11 during the of Nursing (DON) stat morning report 9:30am. However,	of Daily Living (ADL's) and is of bladder and bowel." re plan dated 8/24/11, R4 is at own due to decreased mobility ith interventions for staff to ence every 2 hours and clean episode" and "turning and cility protocol" among others. am, R4 was uncovered and large bath towel rolled up, n her legs in her perineal area. ly soaked with urine as was was under her. The paper paders with urine. Interview with a Aide (CNA), on 9/7/11 at aid that R4 had changed after family), and Z2 (R4's family) on 9/7/11 at 10:40am, and ived to visit R4 at 9am and no check/change either resident ney arrived. am, R1 was again noted to be to bedside. Z1 and Z2 stated no check/change R1 since they when they arrived on 9/8/11. both, R1 was checked and continent pad which she was ely soaked with urine. Z1 and aff had been in since they	F999	99		

AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		145289	B. WI	NG _		C 10/05/2011	
NAME OF PROVIDER HELIA HEALTHC		LEVILLE		4	REET ADDRESS, CITY, STATE, ZIP CODE O NORTH 64TH STREET BELLEVILLE, IL 62223		
	CH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
Observer reposition 9/8/ 3. Acceyear old with dia Trache Respiration indicate ADL's a bladde her to be decread interver reposition keep her inconting every expense others, pressured to check they are position head we was not under head we was	ording to the defemale address of E costomy, Gas atory Failure as R5 is total and is always. The Carbe at risk for sed mobility ntions docurrion her according to the Care Fre ulcers at 10 at 9am on 9 at 10:20 and as noted to have the confirmed to confirmed to confirmed to confirmed to the confi	show no change in st from 10:20am until 12:30pm e Admission Sheet, R5 is a 48 mitted to the facility on 12/7/06 down's Syndrome, strostomy Tube, and . The MDS dated 6/21/11 lly dependent on staff for all s incontinent of bowel and e Plan dated 8/31/11 identifies skin breakdown due to and incontinence. The ment staff are to turn and rding to their facility protocol, and dry, check for 2 hours and clean/dry after do weekly skin checks among Plan indicates she has no	F9	999			

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION IG	(X3) DATE SU COMPLE	
		145289	B. WI	NG _			C 5/2011
	ROVIDER OR SUPPLIER	LEVILLE	•	4	REET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH 64TH STREET BELLEVILLE, IL 62223		
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F9999	arrived at 9am 9/7/ According to the fact AND POSITIONING not currently have a repositioned at least 4. R6's Care Plan chas pressure ulcers Interventions indicar reposition per facilitic checks, monitor skit changes to nurses, ordered. The POS treatments to the hococyx/sacrum ordersaline, apply Santyl as needed. Monito Plan identifies the sent of the was observed in right side to observed in right side to observed in the same odor. On 9/7/11 during to R6 was observed in right side to observed in the same odor. According to the E1 observation, R6's tracknowledged that of the dressing present of the	cility's policy on TURNING G, all bedfast residents that do skin breakdown will be at every 2 hours. dated 8/25/11 documents he is on his coccyx and left heal. It estaff are to turn and y policy, do weekly skin in during care and report provide treatments as documents an order for eels and coccyx/sacrum. The er is to cleanse with normal and Silver Alginate daily and infor effectiveness. The Care facrum wound as measuring from depth. The bed. He was rolled to his entire the his gaping pressure field over. There was nower the packing, and there was nower the packing was the only part the packing was the only part	F9!	999			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		145289	B. WI	NG		C 10/05/2011	
	ROVIDER OR SUPPLIER	LEVILLE	•	40	EET ADDRESS, CITY, STATE, ZIP CODE D NORTH 64TH STREET ELLEVILLE, IL 62223		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	total assistance for living. The MDS a catheter and a colo osteomyelitis of the	all other activities of daily lso indicates he has a urinary stomy. R6 diagnoses include sacrum pressure ulcer. formation identifies R6 to be a	F99	9999	DEFICIENCY		