DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		C	OMB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	COM	E SURVEY IPLETED	
		145290	B. WING _			C 16/2016	
NAME OF I	PROVIDER OR SUPPLIER			-			
MIDWES	T REHAB & RESPIRA	ATORY		727 NORTH 17TH STREET BELLEVILLE, IL 62226			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	rs	F 00	00			
		1/IL83836 F328, F517 3/IL83902 F328, F517					
	F517 related to the	d in an Immediate Jeopardy at failure of the facility to develop ster/Evacuation Plan for over 1000 pounds.					
F 328 SS=D	was not removed a conclusion.	ppardy began on 8/14/15 and t the time of the survey IENT/CARE FOR SPECIAL	F 32	28		3/28/16	
	proper treatment an special services: Injections; Parenteral and enter	stomy, or ileostomy care; ;					
	by: Based on interview review the facility fa plan for a necessar	NT is not met as evidenced y, observation and record ailed to provide a maintenance ry trach change for 1 of 1 ewed for trachs in the sample					
	Findings include:						
LABORATOR	 Y DIRECTOR'S OR PROVIE	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.

03/28/2016

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
		145290	B. WING				C 16/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MIDWES	T REHAB & RESPIRA	TORY			27 NORTH 17TH STREET BELLEVILLE, IL 62226		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 328	On 3/5/16 at 2:00 P position with the bas supporting R3's bac was in a wide bariar out of bed. R3 is m wide bariatric bed. I bed. He was on a v primary (care physi that I must go to the No ambulance arou I'm too big. The ad Nose and Throat (E change trach here. that if there are con- right set up here. I stressful on me to f what I want. I still v to somewhere else help me lose weigh Nurse Aid (CNA) th can't work every da times and that I eat four to five times a away." R3 is 32 ye On 3/14/16, at 3:00 concerns with the v some irritation at tir become dependent On 3/13/16, at 9:34 interviewed by telep just talked to Z2 on was still willing to po procedure in the fac and her son wanted another facility befor 3 or 4 years. He was	M, R3 was in bed in a sitting ck of the bed raised ck. R3 is massively obese and tric bed. R3 was unable to get nassively obese and was in a R3 was unable to get out of vent. He stated, "Z1 is my cian). He changed the order e hospital for trach change. und here can move me cause ministrator found an Ear, ENT) doctor that said he would That doctor has concerns nplications there won't be the think it would be less have it done here. That is vant to get moved out of here for long term care that can t. There is only one Certified at I like doing my bath and she y. They say I refuse care at all the time. I do order pizza week but I give some of it ars old. PM, R3 stated his only ent all the time is it causes nes and he worries he may	F 3	28			

Facility ID: IL6001341

If continuation sheet Page 2 of 16

PRINTED: 04/25/2016

		AND HUMAN SERVICES					FORM	APPROVED
	T OF DEFICIENCIES		(X2) MUL	TIPL	LE CONSTRUCTION	0	MB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:						PLETED
		145290	B. WING					C 16/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CC	DE		
MIDWES	ST REHAB & RESPIRA				27 NORTH 17TH STREET BELLEVILLE, IL 62226			
(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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 328	trouble breathing. S get a new bed for R he gained so much because he is afraid but finally agreed to stated a lot of peop helped stabilize R3 stated that R3 wear He doesn't have an he had when he we fit him. R3's March 2016 P documents R3 had diagnoses: Respira and Vent. R3's Nutritional Rec documents R3's we R3's Minimum Data documents R3's we R3's Minimum Data documents he requ two staff members R3's Dietary Progre documents " Last re # (pounds) in June August 4th, 2014 ac Dietary Assessmen "Last recorded wt w 2015. (Up) 263.1 p admit weight of 768 Daily Skilled Nurse' 11:40 AM documen (Z1, Primary Care F	She stated the facility had to R3 a few months ago because weight. R3 refused at first d to be in the mechanical lift, o move to the new bed. Z3 le that worked in the facility when he was moved. Z3 rs a hospital gown all the time. by clothes except for the ones ent to the facility, but they didn't hysician's Order Sheet the following partial atory failure, Morbid obesity, cord, dated 8/6/14, eight as 768.9 pounds (lbs). a Set, dated 1/18/16, irres extensive assistance of for bed mobility and is bedfast. ess Note, dated 7/22/15, ecorded wt (weight) was 1032 2015 (up) 263.1 # since dmit wt of 768.9#." t, dated 8/6/15 documents vas 1032 #'s (pounds) in June pounds since August 4th, 2014,	F 3	28				

If continuation sheet Page 3 of 16

		AND HUMAN SERVICES				FORM	1 APPROVED	
		& MEDICAID SERVICES		TIDI			0.0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED	
							С	
		145290	B. WING			03	/16/2016	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
MIDWES	T REHAB & RESPIRA	ATORY			27 NORTH 17TH STREET BELLEVILLE, IL 62226			
		TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECT		(VE)	
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI		(EACH CORRECTIVE ACTION SHOU	D BE	(X5) COMPLETION DATE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE	
F 328	Continued From pa	.ge 3	F 3	328				
	Daily Skilled Nurse'	s Note, dated 12/30/15 at						
		ts "(Z1) here. Seen resident in						
		and oriented times three) Z1) assessed res (resident) c						
		nslating R/T (related to) vent						
	use. (Z1) explained	d reasoning behind why trach						
		ed @ Hosp (hospital) c onologist for safety. Resident						
		T (Respiratory Therapist) to						
	change trach here							
	dated 1/13/16, docu	Physician's Progress Report, uments "Diagnoses:						
	from the excessive	(a form of obesity that results consumption of food. It is						
		Int intake of food that goes ne body requires) which is						
		uiring ventilatory support."						
	The Note documen	ts "This patient has been						
		us complaints about neglect he trachea. He feels he is						
		d I am not exactly sure but he						
	won't tell me. He w	on't let the trachea tube be						
		't look at it this morning, he						
		but the corporate nurse rday and it is green, foul						
	smelling, extremely	red and he won't allow						
	cleaning."							
	Daily Skilled Nurse'	's Note, dated 1/27/16						
	documents "6:45 Pl	M Resident went on vent per						
	-	needed. No resp (respiratory)						
	distress noted."							
	Daily Skilled Nurse'	's Note, dated 2/10/16						
		ere. Held conversation c (with)						
		nge it not being safe to lity. Said go to hospital."						
		mentation in R3's medical						

Facility ID: IL6001341

If continuation sheet Page 4 of 16

					APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERV			0	OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NUM		LTIPLE CONSTRUCTION DING	_	COM	E SURVEY PLETED	
145290	B. WINC				C 16/2016	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
MIDWEST REHAB & RESPIRATORY		727 NORTH 17TH STREE BELLEVILLE, IL 62226				
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIE       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY       TAG     REGULATORY OR LSC IDENTIFYING INFORMA	FULL PREF	IX (EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPF FICIENCY)	BE	(X5) COMPLETION DATE	
<ul> <li>F 328 Continued From page 4 record as what reasons the trach chang safe to complete in the hospital.</li> <li>R3's Physician's Order Sheet, dated 2/1 documents "TOO risky to change trach (Z1) said to go to hospital for trach char (R3) refuses."</li> <li>Daily Skilled Nurse's Note, dated 2/27/1 PM, documents "Residents trach cuff le (Z1) notified and gave me an order to se resident out to the hospital. Resident refigio to the hospital, he has been educate risks of his health if he does not go to the and still refuses to be sent. He has bee on 15 minute checks. Resident shows ( (signs or symptoms) of respiratory distration of the resident set of the norm (room) to be take off vent. Unable remove from vent R/T hole resistates in trach. Req (Request) to go to hosp."</li> <li>Daily Skilled Nurse's Note, dated 2/28/1 AM documents "This writer spoke c resiabout his concerns of his leak in trach or Resident states that he understands. M concerns of doing change of cuff @ bec Resident states that he is comfortable or to have cuff changed at hospital and is vigo at this time. Will continue to monitor protective oversight." Note continues to document "(Z1) aware of residents req to go to hospital for trach change."</li> </ul>	e was not 0/16 here. I ige. He 6 at 9:30 aking. end fuses to d on the le hospital n placed no) s/s ess and 6, at his writer e to cuff of 6 at 11:30 dent uff. ID's diside. MD order willing to for for for at 11:45	328				

Facility ID: IL6001341

If continuation sheet Page 5 of 16

		AND HUMAN SERVICES				FORM	APPROVED	
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA					IB NO. 0938-0391 X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	i		PLETED	
		145290	B. WING				C 16/2016	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
MIDWES	T REHAB & RESPIRA	TORY			727 NORTH 17TH STREET BELLEVILLE, IL 62226			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 328	Continued From pa need for transport v ambulance." Daily Skilled Nurse' PM, Z15, local amb call. Unable to loca transport res from ( documents "Fire De ambulance service, transport him out of documents "Hospita resident R/T staff to stretcher." Daily Skilled Nurse' PM, documents "Re from (Z16) remains 911. Resident rema remove him from ve documents "Staff co emergency support was no further docu facility will address change on this date Daily Skilled Nurse' documents " Z2, Ea here and assessed performing the tract outcomes such as i	ge 5 vorking on locating bariatric s Note, dated 2/28/16 at 12:20 ulance service, ret (returned) the bariatric ambulance to facility)." Note at 2:00 PM ept et (and) Z16, local here. Unable to safely building." Note at 2:30 PM als in area decline to accept basist pt (patient) off s Note, dated 2/28/16 at 3:15 emains in Rm. Ambulance in facility R/T facility calling ins on ventilator. Unable to ent." The Note at 3:30 PM ontinue to wait for (County team) direct to arrive." There umentation regarding how the R3's trach and need for trach a. s Note, dated 3/2/16 ars/Nose/Throat Specialist, patient. Patient educated that h change may cause adverse f during the procedure the	F 3		DEFICIENCY)			
	trach can not be pu enough oxygen sup shock an death. Pa understanding. Pat and voiced he was potential outcome. Daily Skilled Nurse'	t in place he will not have ply causing a heart attach, atient verbalized tient was able to ask questions informed of the procedure and						

If continuation sheet Page 6 of 16

		AND HUMAN SERVICES					FORM	04/25/2016 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	0	(X3) DATE COM	E SURVEY PLETED
		145290	B. WING					C 16/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE,	ZIP CODE		
MIDWES	T REHAB & RESPIRA	TORY			27 NORTH 17TH STREET ELLEVILLE, IL 62226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 328	and challenges. In and unwillingness to position where his of him at this time sur meet his needs. Sy desire to live and to with his care and pu and possible go into Resident voiced he wanted to go into a patient that I would and see if when car Daily Skilled Nurse? PM, "Resident sho distress. Respiration (Complaint of) SOE red blood showing is orders received to se Hospital)." Note at "Resident is stable. time. Respirations Note documents "Not this time but reside distress or symptor behaviors. Remains On 3/5/16, at 2:30 F that R3 currently wa remain in stable co December 2015 the care with (Z15, ambul ambulance compar patients up to 1600 called, (Z16, ambul stated that if somet would be no way to up to 20 people to r	formed patient due to his size o help himself has put him in a options are minimal. Informed rounding areas are unable to poke with resident about his o do so he needed to assist ut in the work to loose weight o a bariatric program. wanted to get better and bariatric program. Informed make calls to assist with this n get him into a program. " S Note, dated 3/4/16, at 6:30 wing S/S of respiratory ons are increased. C/O B (Shortness of Breath). Bright in sputum. (Z1) notified c send resident to (Local City 10:00 PM documents (No) blood in sputum at this even and unlabored." This lo way of sending resident at nt is having (no) S/S of ns to be send out. (No)	F3	28				

Facility ID: IL6001341

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		AND HUMAN SERVICES				FORM	APPROVED		
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIP	UE CONSTRUCTION		0938-0391 E SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,				PLETED		
			_			(	C		
		145290	B. WING			03/-	16/2016		
NAME OF F	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE				
MIDWES	T REHAB & RESPIRA	TORY		727 NORTH 17TH STREET					
					BELLEVILLE, IL 62226				
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	NV.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION		
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREF TAG		CROSS-REFERENCED TO THE APPROP		DATE		
					DEFICIENCY)				
			I						
F 328	Continued From pa	-	FS	328	3				
		's trach change. E1 stated it							
		blood oxygen would fall below eart attack or stroke.							
		PM, Z7, Hospital EMS							
		al Emergency Service							
		he was the coordinator for the rvice and was the coordinator							
		es. He said he and his							
		nsible for assisting these							
	ambulance compar	nies with their policies and							
	procedures and lice	ensing.							
	77 stated be was o	ontacted by (Z16) on 2/28/16.							
		B) they were unable to							
		his size. Z7 stated after							
		nation, he contacted (Z15)							
		any had an ambulance that							
		e a bariatric resident. When he was told the ambulance							
	. ,	e a patient who was 1000							
		R3 was 1000 pounds plus and							
	could not be transp	orted by this ambulance.							
	77 stated by them	entented (714 heristria							
		ontacted (Z14, bariatric ated this company had an							
		a two ramp system. He							
		vould hold 700 pounds. (Z14)							
		not transfer R3 due to the							
		hat R3's weight would be							
		n the two ramps. This would hight, equipment and staff							
		with the transfer. Z7 stated							
		not be transferred out of the							
		are he and his superiors at							
		cussed possible alternatives.							
		Ears/Nose Throat Specialist. was Z2 would replace R3's							
		Z7 stated Z2 agreed to do							

Facility ID: IL6001341

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PRINTED: 04/25/2016

		AND HUMAN SERVICES			FORM	04/25/2016 APPROVED 0938-0391			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C				
		145290	B. WING		03/16/2016				
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
MIDWES	T REHAB & RESPIRA	ATORY		27 NORTH 17TH STREET BELLEVILLE, IL 62226					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 328	Continued From pat this procedure. Z7 Administrator notifie facility's stance that for this procedure. ambulance service transport this reside the facility contact h R3 if there was an of On 3/10/16, R3's be inches long. The d into the corridor me Therefore, R3's beet to exit his room. The room measured 46 building there is a w as you enter to the inches wide. The w rail to rail. On 3/10/16, at 2:43 would consider cha of a Respiratory Th R3 weighed 1500 p probably could not without removing a comfortable with th	Ige 8 stated that on 3/1/16, Z1, ed him and said it was the t R3 had to go to the hospital Z7 confirmed there was no in the region that could ent. Z7 stated at no time did him regarding how to transport emergency. ed dimensions were d was 52 inches wide by 87 oor opening from R3's room easured 43.5 inches wide. d could not fit through the door he fire exit door closest to R3's inches wide. As you exit the vooden ramp. There is a gate ramp which measures 49 vooden ramp is 57 inches wide PM, Z2, ENT, stated he inging R3's trach with the help erapist. Z2 stated he was told bounds. Z2 stated the facility get R3 out of the facility wall. Z2 stated he felt is procedure if Respiratory e to assist. Z2 stated he did	F 328						
F 517 SS=J	currently trying to w trach.	7AM, E1 stated the facility is work out a plan to change R3's TEN PLANS TO MEET ISASTERS	F 517			4/1/16			
	The facility must ha	we detailed written plans and							

Facility ID: IL6001341

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		AND HUMAN SERVICES					FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	0	(X3) DATE	E SURVEY PLETED
		145290	B. WING					C 16/2016
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C 727 NORTH 17TH STREET	ODE		
MIDWES	T REHAB & RESPIRA	TORY			BELLEVILLE, IL 62226			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 517	disasters, such as f missing residents. This REQUIREMEN by: Based on observat review, the facility fa operationalize a Dis Evacuation Plan for pounds. This defici Immediate Jeopard (R3) reviewed for D Evacuation Plan in Immediate Jeopard was placed in a bea door dimensions. Findings include: On 3/5/16 at 2:00 P position with the ba supporting R3's bac	AT is not met as evidenced tion, interview, and record ailed to develop and saster Preparedness and r bariatric residents over 1000 ient practice resulted in an ly affecting one of one resident bisaster Preparedness and the sample of 3. The ly began on 8/14/15 when R3 d that is larger than his room	F 5	517				
	out of bed. He was my primary (care pl order that I must go change. No ambula me cause I'm too b Ear, Nose and Thro would change trach	tric bed. R3 was unable to get on a vent. He stated, "Z1 is hysician). He changed the to the hospital for trach ance around here can move ig. The administrator found an bat (ENT) doctor that said he here. That doctor has re are complications there et up here.						
		AM, Z3, R3's mother, was phone. She stated she had						

Facility ID: IL6001341

If continuation sheet Page 10 of 16

		AND HUMAN SERVICES					FORM	APPROVED
		& MEDICAID SERVICES	1			0		0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						E SURVEY PLETED
			A. BOILD	into				C
		145290	B. WING					16/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
MIDWES	T REHAB & RESPIRA	TORY			727 NORTH 17TH STREET			
					BELLEVILLE, IL 62226			
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI	х	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH	OULD	BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APF DEFICIENCY)	ROPI	RIATE	DATE
			ľ					
F 517	Continued From pa	ge 10	F 5	517	,			
		the telephone and he said he						
		erform the trach change						
		cility. She stated R3 had been efore going to this one for						
	about 3 or 4 years.	He was moved by						
		ated the facility had to get a						
		ew months ago because he ight. R3 refused at first						
	because he is afraid	d to be in the mechanical lift,						
		move to the new bed. Z3						
		le that worked in the facility when he was moved. Z3						
	stated that R3 wear	rs a hospital gown all the time.						
		y clothes except for the ones						
	fit him.	ent to the facility, but they didn't						
	On 3/10/16, R3's be	ed dimensions were						
		d was 52 inches wide by 87						
		oor opening from R3's room asured 43.5 inches wide.						
		d could not fit through the door						
		ne fire exit door closest to R3's						
		.5 inches wide. As you exit a wooden ramp. There is a						
		the ramp which measures 49						
	inches wide. The w	vooden ramp is 57 inches wide						
	rail to rail .							
	E1 was interviewed	on 3/14/16 and stated that R3						
	was placed in the 5	2 inch wide bed on 8/14/15.						
	R3's March 2016 P	hysician's Order Sheet						
	documents R3 had	the following diagnoses:						
	Respiratory failure,	Morbid obesity, and Vent.						
	R3's Minimum Data	a Set, dated 1/18/16,						
	documents he requ	ires extensive assistance of						
	two staff members	for bed mobility and is bedfast.						

Facility ID: IL6001341

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		AND HUMAN SERVICES			, i		APPROVED		
		& MEDICAID SERVICES					IB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY IPLETED		
		145290	B. WING			C 03/16/2016			
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
MIDWES	T REHAB & RESPIRA	TORY			727 NORTH 17TH STREET BELLEVILLE, IL 62226				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 517	Continued From pa	ge 11	F 5	517	,				
	R3's Nutritional Rec documents R3's we	cord, dated 8/6/14, eight as 768.9 pounds (lbs).							
	10:00 PM, documer	lurse's Note, dated 6/25/15 at nts "Bed bath given, wt Res (Resident) tolerated le anxiety noted."							
	"Last recorded wt w 2015. (Up) 263.1 p admit weight of 768 PM, E12, "I was he pounds. Two CNAs in the doorway. The pounds on the scale said 1000 pounds b higher and is not lin was over the weigh couldn't use it again because his sides s bed. We got him a PM, E13, CNA state the hoyer lift with th took 6 people to ste alot and moves aro keep him steady.	t, dated 8/6/15 documents vas 1032 #'s (pounds) in June ounds since August 4th, 2014, 8.9 pounds." 3/10/16, at 2:18 ere the night they got the 1230 is used a hoyer. I was standing e weight came out 1230 e. The capacity of the hoyer but the weight part can go up nited. Once we figured out he t limit for the hoyer, we n. We know he got bigger started to touch the edge of the new bed." On 3/14/16 at 2:40 ed that she weighed R3 using e built in scale in June 2015. It eady him because he panics und. She stated it is difficult to							
	documents "Diagno form of obesity that consumption of foo intake of food that o	ogress Report, dated 1/13/16, oses: Exogenous obesity (a results from the excessive d. It is caused by a constant goes well beyond what the th is morbid obesity requiring							
		ument located in the front of d. dated 1/25/16. documented							

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DEPAR <sup>-</sup> CENTE	FORM	04/25/2016 APPROVED 0938-0391					
CENTERS FOR MEDICARE & MEDICAID SERVICESSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
145290		B. WING			C 03/16/2016		
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MIDWES	T REHAB & RESPIRA	TORY			27 NORTH 17TH STREET BELLEVILLE, IL 62226		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 517	"(R3) - If Resident is 911 & inform 911 op Ambulance Compar- bariatric ambulance greater than 1400 lk control Ventilator." ( this was an Emerge On 3/14/16 at 11:08 Nurse, LPN; at 11: E3, LPN, ADON; ar interviewed regardin are in place to take was a medical eme stated that a plan w was not in writing. tools which included saw that cuts throug extension cord and Respiratory Therapy key. The walls in R plan would be to us out in R3's room an the hall to the doubl wide enough to acc he was out on the s Ambulance, and the assume Z14 and th over from there. The many people it wou transfer. On 3/14/16 at 11:15 CNA, stated, "I don" nobody told me. At "I would not know h	s in Respiratory distress call berator that Z16, Local ny, ambulance needs to send and resident's weight is os and is dependent on assist On 3/7/16, E1 confirmed that	F 5	517			

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DEPART	FORM	APPROVED								
						MB NO. 0938-0391				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED			
			A. DUILDI	NG.			C			
		145290	B. WING			03/16/2016				
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
MIDWES		TORY		7	27 NORTH 17TH STREET					
MIDWEST REHAB & RESPIRATORY				BELLEVILLE, IL 62226						
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)			
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLÉTION DATE			
ind			inte		DEFICIENCY)					
F 517	Continued From pa	ge 13	F 5	17						
		-								
		PM, Z7, Hospital Emergency								
		MS)Coordinator/Regional								
		Coordinator, stated he was								
		the local emergency service nator for four local counties.								
		director were responsible for								
		pulance companies with their								
	policies and proced									
		6								
		ontacted by Z16, local								
		3/16. He was told by Z16 they								
		sport R3 due to his size. Z7								
		ng this information, he er local ambulance, because								
		in ambulance that could								
		riatric resident. When he								
		iatric ambulance, he was told								
		ld accommodate a patient who								
		r under. R3 was 1000 pounds								
		be transported by this								
	ambulance.									
	77 stated he then c	ontacted Z14, bariatric								
		ed this company had an								
		a two ramp system. He								
	stated each ramp w	ould hold 700 pounds. Z14								
		not transfer R3 due to the								
		hat R3's weight would be								
		n the two ramps. This would								
		eight, equipment and staff to with the transfer. Z7 stated								
		not be transferred out of the								
		care he and his superiors at								
		cussed possible alternatives.								
		1/16, Z1, Administrator								
		d it was the facility's stance								
		the hospital for this								
	procedure. Z7 conf	firmed there was no								

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	-	AND HUMAN SERVICES					FORM	04/25/2016 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICESSTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,		E CONSTRUCTION	0	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		145290	B. WING					C 16/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE	, ZIP CODE		
MIDWEST REHAB & RESPIRATORY					27 NORTH 17TH STREET ELLEVILLE, IL 62226			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 517	ambulance service transport this reside the facility contact h R3 if there was an e 3/9/16 at 3:00 pm, 2 Chief, said that the him or the Fire Dep developing a Disas: recently the Local A contacted the Depa in transporting R3 f at the facility, R3 wa 48 inches wide. Z13 available to transpo- inches wide. Z13 s Emergency for (R3) On 3/10/16, the Fac Procedure book wa documentation in th staff and emergence implement emergen policy and procedur inability to leave his 3/14/16 at 11:25AM other "Evacuation F E1 did not mention this time. At 11:26 drywall evacuation and he stated, "Oh would knock the wa he did not address emergency plan for to the County EMS The Facility's Disas	in the region that could ent. Z7 stated at no time did nim regarding how to transport	F 5	517				

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		AND HUMAN SERVICES				FORM	04/25/2016 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
145290		B. WING	i		C 03/16/2016				
NAME OF PROVIDER OR SUPPLIER				5	STREET ADDRESS, CITY, STATE, ZIP CODE				
MIDWES	T REHAB & RESPIRA	TORY	727 NORTH 17TH STREET BELLEVILLE, IL 62226						
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 517	outage, heating faile any other situation to of the facility in order safety of the facility? Policy & Procedure in cooperation with County Emergency Police and County & The Facility's "Evace not dated, document degrees of evacuat person in charge of of the fire. Initial eva accomplished by how Movement of people the travel of heat ar safety area under ed documents "4. Beck removed by moving possible." The Immediate Jeo 3/15/16. On 3/15/1 were notified of the The Immediate Jeo	leak, flood, electrical power ure, explosion, bomb threat, or that would warrant evacuation er to protect the lives and 's staff and residents." The documents "This plan will be the American Red Cross, the Government office, local Sheriff's Departments." cuation Procedures" for fire, nts "The necessity for varying ion will be determined by the i the fire area as to the extent	F	517					

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