STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145668	A. BUILDING _____ B. WING _____	C 10/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLEVILLE HEALTHCARE & REHAB	150 NORTH 27TH STREET BELLEVILLE, IL 62226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #1344092/II65781	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement safety measures for 2 of 3 residents (R1 and R2) who were reviewed for falls, in the sample of 3, Findings include: 1. R1 was observed on 10/3/13 at 2PM to be lying asleep in a low PVC bed with mat on the floor and alarm in place. R1 had a 3 inch in diameter black purplish area above her left eye with multiple steri strips and bruising under the left eye. Record review of R1's Minimum Data Set (MDS) of 9/3/12 documents R1 has a history of falls; has a diagnosis of Dementia; is cognitively impaired and requires assistance of 1 for transfer. R1's Fall Risk Assessment of 9/23/13 documents R1 has had multiple falls.	F 323		

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

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F 323	Continued From page 1	F 323		

Facilities Unusual Occurrence Tracking Log documents R1 has had 8 falls from 5/28/13 to 9/22/13. All falls document R1 had tried to transfer self either in the bathroom or out of bed.

Facility Unusual Occurrence Report of 9/22/13 documents R1 tried to get up from her bed and fell to the floor. R1 Certified Nurse Aide (CNA) had gone in the room because the bed alarm was going off and R1 was trying to get out of bed. The report documents R1 was sitting up on the side of the bed as E10 left her and got R1's wheel chair to move closer to the bed. R1 stood up and fell before E10 could get to her. R1 was sent to the Emergency Room (ER) with a laceration to the left side of her head and a laceration to her left hand. Report documents under recommendations in place to prevent recurrence, "Padded side of roommate bed - staff education. Inservice of 9/25/13 was attached to the report. The Inservice documents Topic, "Residents that are high risk for falls are not to be left unattended, ask other staff for assistance."

ER report of 9/22/13 documents concussion/injury of the brain and laceration of head and hand.

Nurses Note of 9/22/13 document CNA heard the alarm going off in residents room and went in and turned the alarm off and had R1 sit on the bed while she got the wheel chair. When the CNA (E10) turned around she noticed R1 up and tried to get over to R1 but R1 started to fall before CNA could get to R1. CNA noticed blood coming from R1's head and left hand.

Written note dated 9/22/13 by E10 documents, " Around 11:30AM I went to answer the alarm of

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F 323	Continued From page 2	F 323		

R1 who was trying to get up I the aide, E10 turn the alarm off and turned back on when I turned around Pt (R1) was trying to get up so I told her to sit down on bed when I went to get the wheel chair she was up as I reached for her she had fell I was trying to break fall but she had hit floor. I went to get Nurse who was around the corner from room and told her what happen and showed her what happen to prior to R1."

On 10/4/13 at 10:25AM, E3, Director of Nursing, stated R1 has Dementia and Cognitive Deficit. R1 is one person assist and they remind her not to get up. E3 stated R1 is very fast for someone who is in her 80's. She gets right up. When her alarm is going off we know she needs to get up. E3 stated R1 has the right to fall.

2. R2's MDS of 8/20/13 documents R2 has severe cognitive impairment; always incontinent of bowel and bladder; and requires extensive assistance of 1 for transfer and hygiene.

Facility Occurrence Logs document R2 has had 3 falls since admission on 8/13/13.

On 10/3/13 at 2:10PM, E8, CNA, was observed in R2's room with R2. E8 stated she was getting ready to clean up R2. E8 stated that R2 is able to stand and when she cleans him she stands him up to the dresser and he holds on while being cleaned. E8 states that's how she always does it. Assist R1 up to the dresser and he holds on while being cleaned. E8 asked if that was alright and was told to do what she normally does. E8 went to R2's dresser and got a disposable incontinent brief and then removed the lap top cushion from R2's wheel chair to get him up. E8 did not have a

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F 323	Continued From page 3 gait belt with her during this time. E8 stated she needed to go get soap and had to put the lap cushion on R2 and take him from the room while she got the soap because she is not supposed to leave him alone in his room in his wheel chair. E8 came back with the soap and brought R2 back into his room. E8 still did not have a gait belt. E8 removed the lap top cushion to transfer R1 when E9 and E10's came into the room with a basin, wash cloths, soap, gait belt and a new lap top cushion for R2. E9 and E10 told E8 they came into help her. E8 stated it was too many CNA's and R2 is getting agitated. On 10/4/13 at 9:50AM, E2, Corporate Nurse, stated E8 had been inserviced about using a gait belt. IN-SERVICE TRAINING REPORT of 10/3/13 and 10/4/13 documents Topic: Proper transfer technique with gait belt. "Explanation of proper transfer technique. Staff notified of required use of gait belt with all gait belt transfers. Return demonstrations of above."	F 323		