Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005474	A. BUILDING: ______ B. WING ______	C 11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF BELLEVILLE	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) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 2349557/IL166793	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements are not met as evidenced by:

Based on interview, observation, and record review the facility failed to provide adequate supervision and progressive interventions for 1 of 3 (R2) resident investigated for falls. This failure resulted in R2 having multiple falls and sustaining a Closed displaced fracture of medial malleolus of right tibia and closed avulsion fracture of lateral malleolus of right fibula.

Findings include:

R2's EMR, (Electronic Medical Records), undated documents, that the resident was admitted to the facility on 01/26/22.

R2's EMR dated 10/25/21, documents, a diagnosis of Cerebral Palsy, unspecified.

R2's EMR dated 10/26/21, documents, a diagnosis of unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.

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S9999	Continued From page 2 R2's MDS, (Minimum Data Set), dated 09/05/23, documents, that resident has a BIMS, (Brief Interview for Mental Status), score of 14 out of 15. The MDS documents, that R2 is independent with setup help only for bed mobility, transfer, walk in room, walk in corridor, locomotion on unit, locomotion off unit, and toilet use. The MDS documents, that R2 requires supervision with setup help only for dressing and personal hygiene. The MDS documents, that R2 is not steady, but able to stabilize without staff assistance. R2's Fall Risk Evaluation dated 09/11/23, documents, a score of 15.0. Scoring a 10 or higher makes resident "High Risk" for falls. R2's Care Plan undated documents, "Fall: (R2) is at high risk for falls cognitive deficits, functional deficits, history of falls, visual impairment r/t, (related to), weakness, recent falls, and decreased mobility. 10/07/23 fall with fracture, NWB, (Non-Weight Bearing), RLE, (right lower extremity). 10/20/23 ORIF, (Open Reduction and Internal Fixation), ankle." R2's Nurses Notes dated 01/16/23, at 5:20 PM documents, "nurse was notified that res had fell to her knees in the hallway near 300-hall nurses' station, nurse came to assess res, (resident), and saw res just getting off the floor while holding on to walker, res stated, her legs buckled and gave out, she did not hit her head, nurse assessed res at this time, no injuries noted, res stated, she isn't in any pain at this time, nurse educated res on the importance of taking breaks when feeling tired, making sure to use wheelchair when can no longer walk, NP, (Nurse Practitioner) and POA, (Power of Attorney), has been made aware, no	S9999		

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S9999	Continued From page 3 further concerns noted at this time, VS, (vital signs), 98.2 78 18 122/76 98 RA, (room air)." Intervention dated 01/16/23 documents, "encourage resident to use wheelchair. R2's Nurses Notes dated 02/06/23, at 11:25 AM documents, "This nurse was notified by aid that res had a fall in the activity area. When I made it to the area res was up and sitting in a chair. Vitals was taken B/P (blood pressure):129/20, pulse:80, res (respirations) :18 temp, (temperature) :97.3, O2 97%RA, res stated, she tripped over the rug. ROM, (range of motion), was performed, and res complained of no pain and stated, she landed on her knees." Intervention dated 02/06/23 documents, "Resident educated to be mindful of her environment and avoid tripping hazards." R2's Nurses Notes dated 02/28/23, at 2:56 PM documents, "Resident fell backwards onto her bottom outside in the smoking area, resident's walker was in front of her when she fell. resident did not hit her head and the fall was visually seen by a staff member. Resident stated that she became dizzy and fell, Resident had no injuries noted at this time, no c/o, (Complaints of), pain or discomforts. Resident's BP was elevated 118/100, HR, (heart rate), was 95. This nurse had just administered morning medications 20 minutes prior to fall. NP notified of fall." Intervention dated 02/28/23, encourage resident to sit down in either w/c, (wheelchair), seat or on the seat on her rollator when she is smoking. R2's Nurses Notes dated 04/12/23, at 8:55 AM documents "Res fell to her knees while	S9999		

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ambulating in activity area. Res was able to get back up without assistance, denies pain and did not hit her head. VS are WNL, (within normal limits). no visible injuries noted. NP has been informed. NNO, (no new orders), have been given at this time."

Intervention dated 04/12/23, documents, "Monitor resident for tolerance and endurance. Schedule tasks accordingly."

R2's Nurses Note dated 04/19/23, at 1:01 PM documents, "Writer was informed that res had fallen in dining room and hit her head above her R, (right), eyebrow and has a skin tear to her L, (left), knee. VS are BP-194/86, P-73, R-20, T-97.3, o2- 98 on RA. Res is alert and able to move all extremities without complaints of pain/difficulty. Res was helped up from the floor by 2 staff members using a gait belt. She was able to walk from the dining room to her room without difficulty. Writer informed NP and was given order to send res to (local hospital) for further eval. Res guardian has been informed and has voiced no complaints or concerns."

Intervention dated 04/19/23, documents, "Therapy to evaluate for balancing and strengthening with recs for programming."

R2's Nurses Notes dated 05/09/23, at 10:00 AM documents, "Res fell during smoke break this am. Writer observed res sitting on her knees outside in the smoking area, with her wheeled walker in front of her. Res was assessed for pain and injury. Res denies pain, able to move both upper and lower extremities without difficulty. Res denies hitting her head. VS assessed, BP-78/56, P-103, R-18, T-97.9, o2-97% on RA. Res was helped from her knees onto and sat on the seat

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of her walker, then pushed to her room. Res is lying in bed, call light within reach, bed in the lowest position."

Intervention dated 05/09/23, documents, "Educated resident on taking her time while ambulating."

R2's Nurses Notes dated 05/16/23, at 7:46 AM documents, "Writer informed res was on the ground, Res was observed on her R knee, holding onto to wheeled walker while outside during smoke break. Res said she slipped in the rain. Res denies pain, denies hitting her head. Assessed for pain and injury, none noted. Res guardian has been informed and has voiced no complaints or concerns. VS BP-176/91, P-76, R-18, T-97.2, o2-98 on RA."

Intervention dated 05/16/23, documents, "encouraged (R2) to use wheelchair when going out to smoke, esp. in inclement weather."

R2's Nurses Notes dated 05/24/23, at 9:56 AM documents, "Writer alerted by staff to come to smoke break patio because there was a code blue. Writer observed res lying on the ground unresponsive, pulse faint and irregular. 911 call initiated, while this nurse stayed with res. Writer noticed res breathing was labored and res began to have uncontrollable body movements. EMT, (Emergency Medical Technician), arrived shortly after and res was transferred to stretcher and then to (local hospital). Guardian has been informed, no complaints or concerns have been voiced."

No intervention noted for this fall.

R2's Nurses Notes dated 05/25/23 at 1:46 PM

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documents, "Writer informed by staff that res was on the floor in her room. Res assessed for injury and pain. No visible injury noted, res c/o pain to L hip when standing. VS assessed BP-167/93, P-71, R-18, T-97.1, o2-96 on RA. MD informed and gave order to DC Tegretol, order STAT, (Urgent or Rush), L hip XR (x-ray), CXR (chest x-ray), and labs CBC w/Diff (complete blood count with differential), UA (urinalysis) w/C&S (culture and sensitivity). Res and Guardian aware, no complaints or concerns voiced."

Intervention dated 05/25/23, documents, "Educated resident to rise slowly from her bed or wheelchair when she is feeling dizzy."

R2's Nurses Notes dated 07/03/23, at 12:58 PM documents, "Resident has been having unsteady ambulation this morning. This nurse provided pt education for ambulatory safety and referred a wheelchair, pt denied. Resident was witnessed going out the front lobby door and fell to her knees. Patient complained 5 out of 10 for pain in RLE. This nurse looked over pt no major signs of distress or discomfort. Resident is now using wheelchair and taking a rest from using walker. MD was notified but no answer. This nurse ordered 2 view X-ray on RLE, care ongoing."

No intervention noted for this fall.

R2's Nurses Notes dated 07/06/23, at 7:37 PM documents, "resident at 6:54 reported to the CNA, (Certified Nursing Aide), that she broke her foot from a fall that happened in the shower at 2pm. this nurse asked resident what happened. "Res stated, she fell in shower two time". resident complained of pain on the bottom of her right foot. small skin abrasion on right ankle. Vitals SPO2, (oxygen saturation), 96 RA, T 98.6, R 16,

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S9999	Continued From page 7 P 61, B/P 155/78. ROM was performed. V14 (Physician) notified, Guardian notified. resident is in bed with call light within reach." Intervention dated 07/06/23, documents, "Encourage resident to use shower chair for safety." R2's Nurses Notes dated 07/08/23, at 10:41 AM documents, "Writer informed by CNA that res fell in her room and got herself back up and into her bed. Res was assessed for visible injury, none noted. Res denies pain. VS BP-127/75, HR-58, o2-95% on RA, T-97.1, R-18. MD (V14) informed, gave order for orthostatic BP ... Laying-BP-132/76, HR-63 Sitting-BP-170/110 HR-62 Standing-BP-191/116 HR-63. After reviewing results, MD gave order for res to have STAT CBC, CMP (complete metabolic panel, MAG, (magnesium), TSH, (thyroid stimulating hormone), and a UA. V15 (POA) has been informed, no complaints or concerns have been voiced." Intervention dated 07/08/23, documents, "Ensure proper fitting footwear when up." R2's Nurses Notes dated 07/08/23, at 7:00 PM documents, "Res came to the nurse station to report she had fallen in her bedroom while trying to go to the bathroom. She got herself up. She denied pain to writer, informed POA she was having pain and now could not walk. Writer left message with MD (V14); res being sent to (local hospital) for further eval." Intervention dated 07/08/23, documents, "Encourage resident to ask for assistance when feeling weak."	S9999		

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S9999	Continued From page 8 R2's Nurses Notes dated 07/14/23 at 11:00 AM documents, "This nurse was standing at the nurse's station when (R2) literally came almost running up the hall towards the nurse's station. When (R2) got right up to the nurse's station she called for the nurse, while still almost running, and then abruptly stopped walking/running. When she stopped, she started to go forward, then went to turn and when she started to turn, she lost her balance, went down to left knee twisted herself around and sat on the floor. Advised (R2) to stay where she is while her nurse evaluated her. Able to move left and right legs straight out, pull her knees up to her chest and rotate her ankles without difficulty or c/o discomfort." Intervention dated 07/14/23, documents, "Encourage (R2) to wear leg braces when getting up." R2's Nurses Notes dated 07/17/23, at 9:38 AM documents, "resident found sitting on buttocks in front of wheelchair. Resident stated she was trying to pick up a towel off the floor. resident stated she did not hit her head. ROM performed x4 extremities without difficulty. Gait belt applied and resident assisted off floor back into wheelchair safely. This nurse escorted resident to her room and assisted her back to her bed safely. Nursing supervisor made aware." Intervention dated 07/17/23, documents, "Encourage resident to lock wheelchair prior to leaning forward." R2's Nurses Notes dated 08/12/23 at 10:02 AM documents, "Writer was informed that res had fallen out of bed and gotten herself up and laid back on the bed. Res said she tried to roll over and was on the edge of the bed, that caused her	S9999		

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to fall and strike her back. She complains of pain to her back, a scratch is visible, the scratch is not bleeding. Writer ordered an XR to -cervical spine, dorsal spine, lumbar spine, sacrum and coccyx. Res POA has been informed. No complaints or concerns have been voiced."

No intervention noted for fall on 08/12/23.

R2's Nurses Notes dated 08/18/23 at 9:34 AM documents "this nurse was informed by CNA that res was getting self-off the floor while CNA was entering the room, res stated that she thought she could make it to the restroom without her walker without falling, res stated that she did not use her walker because It was on the other side of the bed, res stated that she fell on her knees, res roommate witnessed the fall, res stated that she is ok and did not hurt herself, this nurse examined res, ROM WNL, res has bruising to the right knee that res stated it was old, res denies having any pain to legs at this time, will continue to monitor and update if condition changes. Res POA (V15) and sister-in-law made aware."

Intervention dated 08/18/23 documents "Encourage resident to make sure she's using her wheeled walker when ambulating."

R2's Nurses Notes dated 09/11/23 at 11:06 AM documents "Aide reported to this nurse that resident had a fall. Resident stated she was throwing away a honey bun wrapper as she fell and hit her chin. Resident said she tried to get back into the bed but wasn't able to lift herself because of pain in Left knee. This nurse checked Vitals T 98.2 O2 97 RR 18 P 69 BP 137/110 and started neuro checks. Resident was provided a PRN (as needed) Narc for pain of chin and legs. Care ongoing."

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Intervention dated 09/11/23 documents "Encourage resident not to bend forward when standing and to ask for assistance when the need is there."

R2's Nurses Notes dated 10/07/23 at 11:32 AM documents "Resident noted on floor in bedroom at 9:44am c/o pain 8.5/10 in right ankle. right ankle noted with bulges and swelling. right pedal pulse palpable. PRN hydrocodone administered. Vitals SPO2 95, T 99, P 94, B/P 120/62, R 22. notified NP and POA. sent resident to (local hospital) ER (emergency room) for eval."

Intervention dated 10/07/23 documents "Encourage resident to reach behind her to feel for surface before attempting to sit."

R2's Nurses Notes dated 10/07/23 at 3:39 PM documents "resident arrived at facility at 3:30pm. With diagnosis for Closed displaced fracture of medial malleolus of right tibia and closed avulsion fracture of lateral malleolus of right fibula. referral to Orthopedic Surgery @ (local hospital group) Orthopedics and Sports medicine 4700 Memorial drive Suite 300 Belleville. Orders to make appointment on Monday for a F/U (follow up)."

R2's Fall investigation dated 10/07/23 documents "Resident was found by staff on floor in room. This nurse went over to her and ask what happened. Resident stated that her right ankle gave out while she was walking in her room. Right ankle noted with swelling and bulges around right ankle. Vitals SpO2 95, T 99, B/P 120/62, R 22. Resident was in extreme pain 8.5/10. PRN hydrocodone given right pedal pulse present. Resident unable to give description. Resident was taken to the hospital for extreme

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S9999	Continued From page 11 pain and suspected fracture or dislocation of right ankle. IDT (Interdisciplinary Team) meeting to discuss fall from 10/07/23. Resident alert and oriented x4. BIMS 14. Resident requires no physical assist with ADLs (activities of daily living) and transfers. Resident is continent of bowel and bladder. RCA: Walked to bed and turned to sit and sit to close to edge of bed and slid off onto floor. All previous fall interventions in place adding encourage resident to reach back with hands and feel before sitting that she's close enough. All parties agree with plan of care. Care plan reviewed and updated." On 11/21/23 at 11:05 AM, R2 observed sitting in her wheelchair in room which is located at the opposite end of the hall from the nurses' station. On 11/22/23 at 10:00 AM, V5, Care Plan Coordinator stated that R2 has interventions for all of her falls except for the falls on 07/03/23 and 08/12/23. On 11/28/23 at 10:15 am, V2, DON (Director of Nursing) stated that she would expect a resident to have an intervention put in place after every fall. She stated that she would expect a resident that has had multiple falls to be supervised closer and moved closer to the nurses' station. Facility policy "Fall Prevention and Management" dated 09/2022 documents, "This facility is committed to maximizing each resident's physical, mental and psychosocial well- being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and	S9999		

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S9999	Continued From page 12 modified as needed. 4. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence." (A)	S9999		