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 |
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| | IL6005474 | A. BUILDING: ______ B. WING ______ | 06/07/2019 |

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| BRIA OF BELLEVILLE | 150 NORTH 27TH STREET BELLEVILLE, IL 62226 |

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| S 000 | Initial Comments<br><br>Annual Licensure & Certification Survey | S 000 | | |
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>(Violation 1 of 2)<br><br>300.610 a)<br>300.1210 a)<br>300.1210 b)<br>300.1210 c)<br>300.1210 d) 2)<br>300.1210 d) 5)<br>300.3240 a)<br><br>Section 300.610 Resident Care Policies<br><br>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.<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as | S9999 | **Attachment A**<br>**Statement of Licensure Violations** | |

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applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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:

2) All treatments and procedures shall be administered as ordered by the physician.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour,

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seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based on observation, interview, and record review, the Facility failed to provide timely turning and repositioning for 2 of 11 residents (R72 and R309) reviewed for pressure ulcers in the sample of 54. This failure resulted in R309 developing three new deep tissue injuries; one on both of R309's heels and one on R309's medial left foot.

Findings include:

1. On 05/28/19 at 9:37 AM, R309 had a wound vacuum (negative pressure wound therapy) in place to a pressure ulcer on R309's right thigh, and a dry dressing to a pressure ulcer to R309's left ischium. R309 had pressure relieving boots on bilateral lower legs. The right boot was turned to the side, with R309's heel pressing into the side of the boot instead of cradled in the heel area of the boot. V16, Certified Nurse's Aide (CNA) removed the boots to conduct a check of R309's skin. R309 had dark maroon colored, deep tissue injuries to both heels and the top medial left foot, each one about the size of a

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nickel. R309 stated the pressure areas on R309's heels and left foot are new today. R309 stated (V17, Wound Nurse), came in early this morning and changed the dressing on R309's left buttock around 6:00 AM, and R309 had not been turned and repositioned since then (about 3 and 1/2 hours). R309 stated sometimes staff will turn R309 when R309 asks, but other times they answer R309's call light and R309 asks to be turned. R309 reported staff say they will be right back, but then don't return.

On 05/29/19 at 9:30 AM, R309 was heard stating, "I think I need to be turned to the other side now." Upon entering R309's room V14, CNA, was getting ready to turn R309 from R309's left side to right side. R309 stated R309 had been turned at about 2:00 AM, then again at about 6:30 AM when V17 changed R309's dressing. R309 had been incontinent of soft brown bowel movement (BM) and R309's dressing to left ischial wound was soiled. V14 removed it and went to let the nurse know R309 would need a new one. V14 cleaned R309's rectum and buttocks, then V17 came in and applied a new dressing to the pressure ulcer on R309's left ischium. V17 stated R309 has new DTIs (deep tissue injury) to R309's bilateral heels and left medial foot. V17 confirmed V17 had changed R309's dressing at about 6:30 AM this morning. R309 stated R309 had been lying in the same position since V17 had changed R309's dressing. After V17 completed R309's dressing change, V14 turned and repositioned R309 onto R309's right side.

On 05/29/19 at 12:00 PM, R309 remained on R309's right side. R309 confirmed that R309 had not been turned and repositioned since V14 turned R309 after R309's dressing was changed.

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On 05/29/19 at 1:04 PM, R309 was still lying on R309's right side. R309 stated, "I wish they would turn me again. I'm getting uncomfortable." On 05/29/19 at 1:57 PM R309 continued to lay on R309's right side.

On 05/29/19 at 2:20 PM, R309 was sitting up in bed. R309 stated V14 had come in and turned R309 at 2:00 PM. R309 had been lying on R309's right side for four hours.

On 05/30/19 at 3:25 PM, R309 verbalized concern due to new pressure areas on heels. R309 stated R309's feet/heels are supposed to be floated, but they are laying on the pillow, not floating. Both of R309's feet were noted to be on top of a pillow, including heels, with no part of feet or heels floating. Pillow was flattened by the weight of R309's feet. R309 stated R309 has been a paraplegic since 1993, and R309 and caregivers at home have always taken very good care of R309's feet because R309 knows R309 is at risk for more skin breakdown. R309 stated R309 did not have pressure areas on R309's feet before R309 was admitted to this facility.

R309's Minimum Data Set (MDS) dated 05/11/19, documents, in part, a Brief Interview for Mental Status (BIMS) score of 15, indicating R309 is cognitively intact. The same MDS also documents R309 requires extensive assist of staff for turning and positioning in bed. The MDS documents R309 was admitted to the Facility on 05/4/19 and had two stage 4 pressure ulcers that were present on admission, and documents R309 did not have any deep tissue injuries present on admission.

R309's Face Sheet documents R309's diagnoses includes, in part, a stage 4 pressure ulcer to her

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right buttock, acute osteomyelitis to right femur, a stage 4 pressure ulcer to left Ischium, and paraplegia.

A Progress Note by V17, dated 05/6/2019 at 11:20 AM, documents, "Skin/Wound Note Text: new admission skin assessment completed. Res (resident) noted to have a stage 4 to right hip and stage 4 to left ischium. wound vac (vacuum) applied to right hip as ordered. (Sodium Hypochlorite moistened gauze) applied to left ischium. Res is noted to be a paraplegic. Res is incont. (incontinent) of B&B (Bowel and Bladder). 16F (French)30cc (indwelling urinary catheter) in place. Res to be in a bariatric bed with air mattress. RUE PICC (Right Upper Extremity Peripherally Inserted Central Catheter) noted. All wound orders reviewed with resident. "

A Progress Note dated 05/29/2019 at 10:31 AM, documents, "Skin/Wound Note Text: during skin assessment this am res noted to have 3 new DTI (deep tissue injury) to lower extremities. Res made aware. Pressure relieving boots) in place at all times. Res is T&R (Turned and Repositioned) Q (every) 2 hours. MD (Medical Doctor) made aware and skin prep to areas noted. (Special Wound consultant) will assess on 5/30. "

R309's Skin and Wound Report dated 05/29/19, documents, "#3- Pressure-Deep Tissue Injury Right Heel; Status New-1 day old: Acquired: In-House Acquired; #4- Pressure- Deep Tissue Injury Left Heel; Status New-1 day old; Acquired: In-House Acquired; #5- Pressure- Deep Tissue Injury Medial Left Foot; Status New- 1 day old; Acquired; In-House Acquired". The Skin and Wound Report dated 05/30/19 documents: "#6-Pressure- Deep Tissue Injury Right Calf (Lateral); Status New-2 hours old; Acquired:

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Acquired In-House".

A Progress Note by V17 on 05/30/19 at 12:44 PM documents, "Res evaluated by (special wound consultant) this am and noted res to have another DTI to right lower leg caused from (pressure relieving boot). NP (Nurse Practitioner) ordered for resident's feet to float on pillows while in bed and with every turn and re-position. New order to have therapy consult to suggest proper cushion/boot that would be appropriate to prevent further injuries. Res made aware and MD of new orders. Res got shower this shift."

R309's Physician Orders (PO) dated 05/30/19 documents, in part, "Therapy to evaluate res. for proper type of boot/cushion for bilateral feet to prevent further injuries" and "keep bilateral feet floating on pillow with every turn and re-position."

R309's undated Care Plan documents the "Focus of Skin: (R309) is at risk for skin complications related to history of necrotizing fasciitis to right hip, history of pressure area to left ischium, incontinence and decreased mobility." The interventions for this focus do not include turning and repositioning R309 routinely.

On 05/30/19 at 3:41 PM, V17 stated "floating R309's heels" means R309's heels should not be touching anything. V17 stated R309's feet should be propped up on two or three pillows to keep feet off the bed. V17 stated R309 should be turned and repositioned at least every two hours, and V17 had been in servicing staff regarding this.

On 06/5/19 at 9:07 AM, R309 stated that R309 had been turned at 12:00 AM last night, then R309's call light had come unplugged from the

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wall, and someone finally came in around 5:00 AM and turned R309 when R309 yelled for help. R309 stated R309 needs to be turned now because R309 was starting to have pain from lying in one position for too long. R309 put R309's call light on to call for assist, and V23, Restorative Aide came to assist R309.

On 06/6/19 at 12:30 PM V2, Director of Nursing (DON), stated V2 would expect a resident who has pressure ulcers or is at risk for pressure ulcers to have a low air loss mattress, pressure relieving boots, and they should be turned and repositioned at least every two hours.

The Facility's undated policy, "Skin and Wound Management Guidelines" documents, in part, "New Facility Acquired Wounds: 3. Ensure immediate interventions to relieve pressure from the area are in place." This policy also documents: "Additional Oversight and Management: 9. During rounds, ensure resident are positioned correctly and heels are off loaded. and 10. Coordinate with Administrator for facility cues to remind staff to turn and reposition residents every 2 hours."

(B)

(Violation 2 of 2)

300.610 a)
300.1210 a)
300.1210 b)
300.1210 b) 5)
300.1210 c)

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300.1210 d) 6)
300.3240 a)

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

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable.

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

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

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.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations were not met as evidenced by:

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A. Based on observation, interview, and record review, the facility failed to provide supervision and implement interventions to prevent falls for two of two residents (R72 and R93) reviewed for falls/supervision in the sample of 54. This failure resulted in R72 rolling out of bed and sustaining a large skin tear/wound requiring 14 staples.

Findings includes:

1. On 05/28/19 at 12:20 PM, R72 was in bed. The bed was not in a low position and there was no bolster mattress in place. R72 had a dressing to the scalp/top of R72's head.

On 05/29/19 09:41 AM R72 was picking at the large opened wound to R72's head while at the nurse's station.

The facility's pressure ulcer /wound log, dated 05/23/19, documented R72 had a wound to R72's scalp measuring 2.6 centimeters (cm) by 1.2 cm by 0.2 cm.

R72's Fall Risk Evaluation, dated 10/3/18, documented a score of 12, 10 or more indicating a high risk for falls.

R72's Minimum Data Set (MDS), dated 04/5/19, documents R72 was severely cognitively impaired. The MDS documented R72 was totally dependent with two plus person physical assist for bed mobility. The MDS documents R72 has limited range of motion on both sides of lower and upper extremities.

R72's Care Plan, with an undated goal, documented R72 was at risk for falls due to increased confusion and decreased mobility. The Care Plan documented R72 relies on staff

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assistance with Activities of Daily Living and mobility. The Care plan did not document R72 required two-person assistance with bed mobility although she had been assessed as requiring two persons. R72's Care Plan Interventions, dated 09/17/19 documented R72 should have a bolster mattress in place and a low bed.

On 05/30/19 at 10:11 AM, V2, Director of Nurse's, DON provided an incident report regarding the incident which occurred on 4/12/19. V2 stated a CNA turned around to do something while R72 was in bed, and R72 rolled out of bed.

The Facility's Fall Report, dated 04/12/19, documented, "Writer called to resident's room to find resident lying in assigned bed bleeding from the top of head. States CNA (Certified Nurse's Aide) told her she was performing care R72 rolled out bed onto the floor beside." The report documented the CNA turned around to get a towel, and the resident rolled out of bed. The report documented the CNA was unable to prevent resident from falling at that time. The report documented 911 was called, and R72 was sent to the local hospital for treatment. The report documented only one CNA was providing care when this incident occurred.

R72's Nurse's Note, dated 04/12/2019 at 11:21 AM documents, "This nurse spoke with (Hospital Registered Nurse) at (local hospital). (Local Hospital RN) reported to this nurse that resident is in stable condition and had a CT (Computed tomography) of head and was clear." The Nurse's Note documented R72 had a 7-centimeter laceration which was closed by staples.

The Hospital Report, dated 04/12/19, documented R72 sustained a laceration to R72's

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head requiring 14 staples.

On 06/6/19 at 10:45 AM, V17, Licensed Practical Nurse (LPN)/Wound Nurse, stated R72 returned from the hospital with multiple staples to R72's head. R72 said after the staples were removed, R72 because to pick at the area and that is what caused the wound.

2. On 05/28/19 at 2:25 PM, R93 was outside smoking on the patio. There were no staff present.

On 05/28/19 4:05 PM, R93 was walking down the hallway with a wheeled walker. R93's gait was shuffled.

R93's MDS, dated 01/22/19, documented R93 required staff supervision with one physical assistance during off unit locomotion.

R93's Nurse's Note, dated 10/12/18 documented R93 fell outside while out on the smoking patio.

R93's Care Plan, undated intervention, documents "(R93) re-educated on smoking supervision, and that R93 is not to go out to smoking patio without a staff member."

R93's Nurse's Note dated 02/2/19, documented "Alerted that res (resident) fell out on smoking patio. Found res in sitting position with walker near him. R93 states, 'I just lost my balance.' Assisted R93 back into building. Small abrasion to left elbow." The Note documented "Res reminded that a staff member needs to be with R93 when R93 goes out to smoke."

R93's Nurse's Note, dated 02/10/2019, documented "This nurse was made aware that

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res had fell outside while coming in from smoking. Res stated that R93 was ok and unharmed."

R93's Nurse's Note, dated 02/10/19, "This nurse made aware that resident fell while coming in from smoking. Per care plan R93 should not be outside by self because R93 falls. "

R93's Care Plan, with intervention dated 02/10/19, documents "(R93) will remain on supervised smoking with assistance."

05/30/19 10:00 AM, V29, Activity Director, noted that R93 can smoke independently but needs to be watched because "R93 fell out there."

The facility's Fall Prevention and Management policy, revision dated 10/2018, documented "Care Plan to be undated with a new intervention based on root cause analysis after each fall occurrence."

B. Based on interview and record review, the facility failed to assess, monitor, and implement interventions to address a resident with verbalization of self-injurious behavior for one of one resident (R9) reviewed for self-injurious behavior in the sample of 54.

Finding includes:

R9's Admission Record, undated, documented R9 has diagnoses of anxiety disorder, major depressive disorder and alcohol abuse.

R9's Minimum Data Set (MDS), dated 01/10/19, did not document R9 made statements of self-harm or being better off dead.

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R9's Nurse's Note dated 02/12/2019 at 4:24 PM documented "This nurse was informed that res spoke with (V30, Contracted Licensed Social Worker) who stated that res wanted to kill himself. Res exact words were, 'I want to kill myself and I have a plan.' Res would not state what the plan was. DON, Administrator, and MD all made aware of incident. N.O. (New Order) received to send res to (Local City Hospital) for a psych (psychiatric) eval (evaluation)."

R9's Nurse's notes documented R9 returned to the facility on 02/18/19.

R9's Consulting Psych Service Note, dated 02/19/19, stated R9 returned from the hospital. The Note documented that R9 had no risk issues noted. The note documented R9 returned from the hospital with a change of medications but there were no other comments regarding monitoring R9 for suicide ideations.

R9's MDS dated 2/27/19 did not document R9 wanted to harm self.

There was no documentation in R9's medical record that a further assessment was conducted to address R9's verbalizing suicidal ideations or how the facility was going to monitor R9 for this behavior.

R9's Care Plan, undated, does not address that R9 wanted to kill self or how staff should monitor R9.

R9's May 2019 Behavior Tracking does not address R9 made these statements regarding self-harm.

On 05/31/19 at 10:14 AM, V8, Social Service

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stated V8 didn't write a note because (V30) went directly to nursing. V30 told nurses R9 wanted to kill himself because of eye pain. V8 stated "I usually make notes regarding these issues but because (V30) went to nursing first, that is where the note is. I'm not sure why this isn't in the care plan."

On 06/6/19, at 10:30 AM, V2 stated that V2 would expect staff to monitor residents if they have suicidal ideations. V2 was unsure if the facility had a policy regarding suicidal ideations/self-injurious behavior.

On 06/6/19, at 1:30 PM, V2 stated V2 did not implement the facility policy regarding suicidal ideations because R9 didn't have a history of suicidal ideations and didn't express R9 wanted to commit suicide after R9 returned from the hospital.

The facility's "Procedure/Practice Guidelines for Suicide Ideations", undated, documented "1. Resident's that have a history of suicide ideations/attempt and are a risk for self-harmful behaviors due to history will be assessed upon admission, quarterly, annually and as needed." The Guidelines did not address how the staff should monitor residents who express suicide ideations and for how long.

C. Based on observation, interview, and record review, the facility failed to assess and implement interventions to ensure safe smoking for one of five residents (R9) review for safe smoking in the sample of 54.

Finding include:

R9's Smoking Assessment completed in the

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Electronic Medical Record (EMR), dated 05/22/19, documented R9 had burn holes in R9's clothing, but R9 may independently handle smoking materials. The Assessment did not address how to keep R9 from burning R9 or R9's clothing while smoking.

On 05/28/19 at 11:56 AM, R9 was outside smoking without staff supervision. R9 was wearing a red shirt and had multiple burn holes in the shirt. At 2:24 PM, R9 was again outside smoking unsupervised .

R9's Care Plan, dated 04/29/19, documents R9 is at risk for injury related to smoking. The Care Plan goal was for R9 to be unsupervised with no incidents. There were no interventions related to the burn holes in R9's clothing or how to protect R9 from burning R9 or R9's clothing.

On 06/5/19, at 10:00 AM, V1 Administrator stated V1 was aware of the burn holes in R9's clothing.

D. Based on interview and record review the Facility failed to assess the side rails for an accident hazard for 1 of 12 residents (R39) reviewed for side rails in the sample of 54.

Findings include:

R39's Physician Order Sheet (POS) for May 2019 documents, in part, diagnoses of heart failure, chronic total occlusion of coronary artery, chronic kidney disease-stage 4.

R39's Minimum Data Set (MDS) dated 05/14/2019 documents a Brief Interview for Mental Status (BIMS) score of 13 out of 15 (cognitively intact). R39's MDS documents lower extremity impairment on both sides and bed

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mobility with limited assistance of one staff.

R39's Side Rail Review, dated 05/14/2019 at 3:24 PM, documents in part, "The resident will utilize side rails that are not considered a restraint and will be utilized to enable the resident to attain and maintain R39's practicable level."

R39's Nurses Notes, dated 02/23/2019 at 2:32 PM, documents in part, "Resident remains on follow up related to self-reported fall. No injuries noted or reported. Maintenance man in facility and fixed side rail related to safety."

R39's Incident Report Notes dated 02/25/2019, documents, "Interdisciplinary Team reviewed incident, investigation and findings. (R39) attempted to pull self-up in bed using the side rail, side rail broke causing (R39) to fall. New intervention: maintenance call in to the facility to assess side rail. Care Plan reviewed and updated."

R39's Care Plan, revised on 04/11/2019 documents, in part, "Requires assistance with daily care and needs related to weakness and cardiovascular disease. Requires assistance and supervision with transfer and bed mobility." R39's Care Plan also documents on 2/23/2019 "maintenance call in to facility to assess side rails.'"

On 05/30/2019 at 10:34 AM, V2, Director of Nursing stated, "Yes, (R39's) side rails broke, and it caused R39 to fall. I don't know what was wrong. The side rails malfunctioned, and our maintenance man came and fixed it. I am not sure who oversaw the side rails inspections. I know our new maintenance man does assessments now."

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| S9999 | Continued From page 18<br><br>Siderails Inspections were requested for R39 on 05/30/2019 and were not provided by the facility for R39.<br><br>On 06/05/2019 at 3;26 PM, V1, Administrator stated there was no policy on side rail inspections. The Facility Fall Prevention and Management Policy with a revision date of 10/2018 documents in part, " 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 fall, plan for preventive strategies, and facilitate as safe an environment as possible. All residents' falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed."<br><br>(B) | S9999 | | |