STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Final Observations Statement of licensure violations : 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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 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	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 1	S9999		

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. (Section 2-107 of the Act)
These requirements were not met as evidenced by :

Based on observation, record review and interview the facility failed to supervise wandering residents with poor safety awareness who have access to an unsafe areas for five of five residents (R1, R11, R12, R13, R14) reviewed for wandering behaviors in the sample of 19. This failure resulted in R1 wandering through a stairway door and falling down the stairs to her death.

Findings include:

On 3/13/2015, at 5:30 AM, the door to the stairwell on 300-400 hallway was unlocked but alarmed with a squelch-type alarm.

The Physician's Order Sheet (POS) for March 2015 documents R1 has the diagnoses, in part,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 2	S9999		

as "Senile Dementia with Agitation and Psychosis and Anxiety. The Minimum Data Set (MDS) dated 1/10/2015, documents R1 is severely impaired with cognition, is non ambulatory, requires extensive assistance of 2 staff for transfers and bed mobility, has no limitations to both upper and lower extremities and uses a wheelchair. The current MDS documents R1 has unsteady sitting and standing balance.

The Fall Risk Assessment, dated 2/27/2015, documents R1 is chair bound with a device to prevent falls, is disoriented X 3 (person, place, time) at all times and is a moderate risk for falls. The Elopement Risk Assessment Form, dated 2/25/2015, documents R1 is at risk for elopement from the facility.

The Incident/Accident Report, dated 3/12/2015 at 6:25 AM, documents R1 was confused and had a self releasing seatbelt while seated in a wheelchair.The Incident/Accident Report further documents R1 was observed on the landing of the stairwell and was unresponsive. The Report fails to document the staff involved in the accident or what had happened.

The Nurses Note for R1, dated 3/12/2015 at 6:30 AM, documents, "Summoned to 400 hall, nurse stated resident (R1) was in the stairwell. Noted resident face down with wheelchair on the top of resident. Non responsive to verbal and tactile stimuli, nail bed cyanotic, lips blue-911 (emergency response) in route."

The Prehospital Care Report Summary for R1 from Z3, Paramedic, dated 3/12/2015, documents a call from the facility was received on 3/12/2015 at 6:32 AM, and the ambulance was on the scene at 6:35 AM. The Report Summary documents, in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 3	S9999		

part, "Disposition: Dead prior to arrival. Unwitnessed cardiac arrest/trauma. Breathing: Apneic, absent lung sounds, pale, skin temperature-cool, capillary refill: absent. Left eye-non reactive, right eye-nonreactive, unconscious. EMS (emergency medical service) noted that the patient (R1) was asystole (state of no cardiac electrical activity/flatline, no blood flow) with a very occasional beat, EMS confirmed no pulse times 3. The nursing staff stated they saw the patient (R1) a little before 6:00 AM, and she was asleep in her wheelchair at the nurses station. The staff stated that after they did not find (R1) and around 6:30 AM, they found patient lying prone on a platform down a flight of about 6-8 stairs with a small puddle of blood around her head, and her wheelchair on top of her. Staff stated they called EMS right away. EMS noted upon arrival, the wheelchair was taken off (R1). EMS noted the patient was lying on her side and slightly rolled onto her back, with a towel over her forehead. EMS noted there was a large gash in her head. The patient was pale, cool and dry, had bruising around the eyes, with no pulse, was not breathing. The nursing staff stated (R1) was a DNR (do not resuscitate) and presented EMS with papers. EMS notified dispatch and notified the nurses they need to call the coroner. (R1) was left with the nursing home."

On 3/13/2015 at 12:10 PM, the facility's video/view of dining room north exit, dated 3/12/2015, was observed. On 3/12/2015 at 5:49 AM, R1 is seen leaving the dining room. The video/view of vending machine elevator, common area adjacent to the stairwell entry door was observed for 3/12/2015. On 3/12/2015 at 5:56 AM, R1 is seen in a wheelchair facing the vending machines. At 5:58 AM, 6:02 AM and 6:07 AM, R1 remains in the vending area. On 3/12/2015 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 4	S9999		

6:08 AM, R1 is seen turning toward the stairway/hallway. At this time, the camera loses sight of R1. From 6:08 AM, R4, E12, Certified Nurses Aide (CNA), and R5 enters and exits the elevator with R1 not in sight of the camera. On 3/12/2015 at 6:16 AM, R5 exits the elevator and walks toward the stairwell, then briefly goes out of view of the camera. At 6:37 AM, numerous facility staff are seen going to the stairwell, and then are out of the camera's view.

Numerous attempts to contact E8, CNA by telephone on 3/13/2015 at 10:48 AM, 2:49 PM and on 3/18/2015, at 12:40 PM were unsuccessful. The written and signed statement for E8 dated 3/12/2015 documents, in part, "I came in side entrance and found (R1). I felt for a pulse. I couldn't get one. I jumped over (R1) and ran to the door and screamed for a nurse. (R1) was face down. We were trying to get the wheelchair off her. A nurse gave me scissors to cut her seatbelt. We took the chair off and rolled her over. (E9, Registered Nurse/RN) and (E10, Licensed Practical Nurse/LPN) came to help. I layed down next to (R1) to see if I could get a pulse. Nurses came down the elevator to get to us. When I pushed the door to call for the nurse, the alarm sounded. It was working."

On 3/13/2015 at 7:00 AM, E9 reported she worked the midnight shift of 3/12/2013. E9 stated, "I saw (R1) sitting in the hallway between the lobby doors and 300/400 hall with a seat belt alarm on about 5:50 AM. I was coming off of 400 hall to pass med's (medications) on 300 hall about 6:20 AM and a day aide (E8) came in and yelled, 'I need a nurse. Call 911!' I saw (R1) lying on the landing face first with seatbelt on and no alarm sounding. I tried to get the seatbelt off, but couldn't. I yelled then to go get scissors. (E8) cut

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 5	S9999		

the seatbelt, removed it and pulled the wheelchair out of the way. I rolled her (R1) over and didn't get a pulse. I put a hand on her chest. No respirations, no pulse, no rise of the chest visually. Both hands were cyanotic. Blood was coming out of her mouth. Blood was on the left side of (R1's) forehead. I wiped all the blood off her face. Someone else called the coroner, but I took the return call. (E10) was actually the nurse assigned to (R1). Paramedics came and put an EKG (electrocardiogram) monitor on her. I came upstairs to see if I could help. E11, CNA stayed with (R1). I took the call back for the coroner . He asked who the deceased was. I gave him her name, birthday and next of kin, diagnosis and no funeral home yet. That was it. I don't remember his name. I just told him what he asked."

On 3/13/2015, at 12:55 PM, E10, LPN stated, "I was paged to the 400 hall. The nurse (E9) said (R1) fell down the stairs. Then I just went to the stairwell. (R1) was on the landing after the first set of steps, face down with the wheelchair on top of her. The alarm chimed when I opened the (stairway) door. At that time, I asked if I need to call 911. I was told it was already done. I checked (R1's) pulse-no pulse. I got the wheelchair off her and yelled for scissors. Someone pushed the belt to get it off her. The chair was removed to get access better. It was 6:30 AM, the change of shift. The ambulance arrived around 6:45 AM. They assessed (R1) with no vital signs and pronounced her expired. The ambulance staff called the coroner. They said they have to. I assumed they called the coroner. I called the family member and (Z2), Physician and notified the exchange. (Z2) called right back. I told him (Z2) it was an unfortunate incident and was asked to fax the H & P (history and physical) and face sheet. I gave (R1) medication that morning. (R1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 6	S9999		

is not known to be an elopement risk, but she did wander everywhere with the wheelchair with a seatbelt, usually with her feet. There were no problems with the chime alarm. I used that stairway during the night. It worked. The chime lasts seconds-you can hear the doorbell (chime)from the nurses station."

On 3/18/2015, at 12:10 PM, E15, LPN reported she had worked the night shift of 3/12/2015. E15 stated, "I seen (R1) when (E8) came up and said someone fell down the stairs. (E9) got there before me. I was busy with another resident who was in respiratory distress. The new shift was coming in. I took the steps, looked down to the landing, then called 911, a male dispatcher. I told them there was an accident, that someone fell down the stairs, and we need an ambulance. I asked if (R1) was still with us and was told she was unconscious. I hadn't seen (R1) that night. The last time I saw (R1) was a week ago. (R1) wanders around the facility in a wheelchair."

On 3/13/2015 at 11:00 AM, E11, CNA reported she was working the night shift of 3/12/2015, and came from another resident's room when she saw staff running around. E11 reported she heard (E25), CNA state R1 had fallen down the stairs. E11 stated, "I went to the stairwell door to see and at that moment staff was bringing up the wheelchair. (E9) and someone else was there. I grabbed the wheelchair and helped pull it up the stairs. I saw (R1) rolled onto her back face up. (E10) was there assessing her and waiting for paramedics. (R1) had no response or respirations. A big gash was on the right aside of the forehead. Blood, a medium amount was there. (R1) might have had bruising. The paramedics got there around 6:25 AM. They hooked (R1) to a EKG to see if there was a heart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 7	S9999		

rate and check her pulse. So then they said she was dead. The paramedics told me to stay with the body until the coroner gets there." E11 reported R1 propels herself in the wheelchair using her feet. E11 reported R1 is confused and very hard of hearing, but alert at times. E11 reported she did not hear the stairway door chime that morning. E11 stated, "I have heard it go off before-ding dong, and at other times it is a shrill sound. I usually use the elevator."

On 3/13/2015 at 12:20 PM, E14, Maintenance Director reported that prior to R1's fall, the alarm to the stairway door was set to chime. E14 reported he checks the door alarms every morning after he arrives at 8:00 AM. E14 reported the last time he had checked the stairway door alarm prior to the fall was the morning of 3/11/2015. E14 reported he arrived at the facility for work on 3/12/2015 at 6:45 AM and went to the employees entrance downstairs on the 500 hall. E14 reported usually using the stairs to go upstairs, but someone told him the morning of 3/12/2015 he couldn't use the stairs. E14 reported he checked the door alarm to the stairs after the accident at approximately 1:00 PM, and the alarm chimed. E14 reported the chime alarm "Ding-dongs" until the door automatically closes. E14 stated, "If no staff is located at the nurses station, it would depend on how far down the hall you are if you could here it." E14 reported R1 was known to be a wanderer. E14 reported usually only the employees use the stairs, and if a resident uses the stairs a staff member must accompany them for safety.

On 3/13/2015, at 8:50 AM E3, Vice President of Operations stated, "The alarm that was on the stairway door prior to 3/12/2015 sound was different. It went ding dong and stopped as soon

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 8	S9999		

as you went through the door. The alarm was functioning when (R1) went down. (E7), CNA checked on (R1) prior to the accident. (R1) liked to sit in front of the vending machine. E7 said he rubbed her back. We have (R1) going into the vending area on tape. You see (E7) doing rounds. He's a night shift CNA. The stair door to the 300/400 hall only sounded once, then stopped." E3 reported R1 would wander throughout the facility in her wheelchair.

On 3/13/2015 at 10:00 AM, R5 was asked if she had witnessed R1 go through the door to the stairwell, or if she had heard an alarm sound on 3/12/2015 between 6:15 AM and 6:20 AM. R5 refused to respond. On 3/13/2015 the other residents, R4 and R7 who were viewed in the video of the vending, elevator and stairwell area were interviewed. Both R4 and R7 reported they did not see R1 or knew of R1's accident the morning of 3/12/2105.

On 3/17/2015 at 1:20 PM, Z1, Deputy Coroner reported the preliminary report of the cause of R1's death is blunt force trauma to the head and possibly a broken back. Z1 reported an autopsy will be performed on R1. Z1 reported if the facility calls 911, the call goes straight to the local police department dispatcher. Z1 reported the police would normally respond, but the information provided by E9 wasn't given properly, so only an ambulance responded.

On 3/17/2015 at 2:05 PM, Z2, Physician and the facility Medical Director reported R1's fall down the stairs could have caused her death. Z2 stated, "I was livid this happened."

R1's Care Plan, dated 2/26/2015 documents, in part, "(R1) is an elopement risk/wanderer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 9 Resident wanders aimlessly, impaired safety awareness. Disoriented to place. Per Elopement Risk Assessment, (R1) is at risk for leaving facility unattended." Interventions documented include; Apply (attached safety monitor that alerts staff a resident has left the building) 2/27/2015. Check placement and function per policy. Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television. Identify patterns of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Monitor every 15 minutes until (attached safety alarm) obtained and then RN (as needed). R1's Care Plan revised on 3/04/2015 documents, in part, (R1) is at risk for falls related to gait/balance problems. (R1) maintains bad posture while in chair. R1 slouches and slides forward in chair. (R1) wears a seatbelt for security and to remind her to push herself back. (R1) is able to release seatbelt herself." R1's Care Plan also documents she has impaired cognitive function/dementia with an intervention that includes; Needs assistance with all decision making. 2. On 3/13/2015 at 2:00 PM, E1, Administrator reported and provided documentation that R11 through R14 have poor safety awareness and have the potential to wander to the stairwell. Throughout the survey R11, R12, R13, and R14 were observed wandering around the facility propelling themselves in wheelchairs. R11's Elopement/Wandering Risk Assessment, dated 1/15/2015 documents R11 ambulates independently with or without the use of an	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 10	S9999		

assistive device, including a wheelchair, and is cognitively impaired with poor decision making skills. R11's Fall Risk Assessment dated 1/14/2015 documents R11 is disoriented X 1 and has a balance problem while standing and walking.

R12's Elopement/Wandering Risk Assessment Form, dated 2/25/2015, documents R12 ambulates independently and has a hearing, vision or communication problem. R12's last Fall Risk Assessment dated 2/03/2015 documents is a moderate risk for falls, requires a device to prevent falls, is disoriented X 3, and has balance problems while standing and walking.

R13's Elopement/Wandering Risk Assessment Form, dated 1/24/2015, documents R13 ambulates independently, is cognitively impaired with poor decision making skills, wanders without a sense of purpose, and is at risk for elopement. R13's Assessment of Fall Risk dated 2/27/2015, documents R13 is chair bound and requires the use if assistive devices.

R14's Elopement/Wandering Risk Assessment Form, dated 2/25/2015 documents, in part, R14 ambulates independently with or without the use of an assistive device, has hearing vision or communication problems and is cognitively impaired with poor decision making skills. The Elopement Assessment documents "(R14) wanders through the facility, will not attempt to leave out doors." R14's Fall Risk Assessment, dated 2/05/15 documents R14 is a high risk for falls, is disoriented X 1, is legally blind and requires the use of an assistive device.

On 3/17/2015, at 10:46 AM, E1 reported the facility does not have a door alarm policy. E1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 11 reported the facility does not have a policy to address wandering residents, but will immediately develop and implement one. The facility's policy and procedure, entitled, 'Fall Management' dated 1/2015, documents, in part, "It is the policy of the facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Safety interventions will be implemented for each resident identified at risk using a standard protocol. Facility staff are responsible for assuring ongoing precautions are put in place and consistently maintained. The resident's environment will be kept clear of clutter and remove hazards. Residents will be observed every 2 hours to ensure the resident is safely in bed or chair." (AA) 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 300.3240a) 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 12 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 resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 13 agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on record review and interview, the facility failed to provide a safe transfer technique for one of three residents (R1) reviewed for transfers and falls in the sample of 19. Findings include: The Minimum Data Set (MDS) dated 1/10/2015, documents R1 is severely impaired with cognition, is non ambulatory, requires extensive assistance of 2 staff for transfers and bed mobility, has no limitations to both upper and lower extremities and uses a wheelchair. The MDS documents R1 has unsteady sitting and standing balance. The Fall Risk Assessment, dated 2/27/2015, documents R1 is chair bound with a device to prevent falls, is disoriented X 3 (person, place, time) at all times and is a moderate risk for falls. The Incident/Accident Report, dated 3/05/2015 at 4:15 PM, documents R1 was being transferred by one Certified Nurses Aide, (CNA) from the wheelchair to bed. The Report documents R1's wheelchair was locked, but it moved during the transfer, and R1 fell on her stomach, hitting her head on the floor. R1 sustained a small hematoma on the right side of the forehead above the eye and had a nosebleed .The Report fails to document if a gait belt was used during	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 14	S9999		

the transfer of R1. The Plan Of Action to Prevent Reoccurrence, dated 3/05/2015 documents, in part, "Assist of 2 to transfer."

On 3/17 and 3/18/2015, numerous attempts were made to contact E23, CNA involved with R1's fall of 3/05/2015, but were unsuccessful. An undated and signed written statement from E23 documents, "I was transferring (R1) from her bed to her wheelchair. The wheelchair unlocked, and (R1) sat at the edge of the wheelchair and slipped out. (R1) fell on her stomach bumping her face, causing her nose to bleed." The statement fails to documents if E23 used a gait belt for the transfer of R1.

The Nurse's Note dated 3/05/2015 at 4:15 PM, corroborates the Incident/Accident Report for R1 of 3/05/2015.

The X-ray Report of R1's facial bones and orbits, dated 3/05/2015, documents "Reveals no evidence of fracture."

R1's Care Plan, dated 3/04/2015, documents, in part, "(R1) is at risk for falls related to gait/balance problems. (R1) maintains bad posture while in a chair, and slouches and slides forward in the chair. (R1) wears a seat belt for security and to remind her to push herself back." Interventions in R1's Care Plan include, "Remind staff (educate) to lock wheelchair for transfers. Transfer with 2 assist using gait belt."

The PT (Physical Therapy) Evaluation and Plan of Treatment for R1, dated 3/06/2015, documents, in part, "(R1) was referred to PT due to recent fall while nursing staff was transferring (R1) without a gait belt."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	A. BUILDING: _____ B. WING _____	C 03/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST REHAB & RESPIRATORY	727 NORTH 17TH 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
S9999	Continued From page 15 On 3/18/2015 at 3:35 PM, E1, Administrator reported E23 was disciplined for not using a gait belt to transfer R1 on 3/05/2015. The facility's policy and procedure, entitled, 'Fall Management' reviewed 1/2015, documents, in part, "It is the policy of the facility to have a Fall Prevention Program to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Safety interventions will be implemented for each resident identified at risk using a standard protocol. Facility staff are responsible for assuring ongoing precautions are put in place and consistently maintained." (B)	S9999		

PLAN OF CORRECTION

PROVIDER: Midwest Rehabilitation and Respiratory Center
ADDRESS: 727 N. 17th Street, Belleville, IL 62226
ID NUMBER: 145290/0051432
SURVEY DATE: March 19, 2015
TAG NUMBER: 300.610a) 300.1210 b) 300.1210 c) 300.1210d) 6) 300.3240a)

1. ***Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***

R1 no longer lives in the facility.
R11 has been reassessed and is not at risk for Elopement/Wandering. Careplan has been updated accordingly.
R12 has been reassessed and is not at risk for Elopement/Wandering. Careplan has been updated accordingly.
R13 has been reassessed and is at risk for Elopement/Wandering. Careplan has been reviewed and updated accordingly. Wanderguard bracelet has been added for her safety. Supervision and monitoring interventions were added along with diversional activity interventions.
R14 has been reassessed and is not at risk for Elopement/Wandering. Careplan has been updated accordingly.

2. ***How will you identify other residents having the potential to be affected by the same deficient practice?***

Residents identified to "wander" have the potential to be affected by this alleged deficient practice.

3. ***What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?***

Double doors on main level leading to the stairwell will be kept closed as a standard as a deterrent to the stairwell door.

The Volume and intensity of the alarm for the stairwell door was immediately increased. Completion Date: 3/12/15

The alarm on the stairwell door is set to "instant." The instant setting for this particular alarm requires a key code entry to silent the alarm. The alarm will continue sounding even after the door shuts until someone keys in the shut off code.

All exterior doors are closed with delayed egress alarms along with secondary keyed alarms, and a few with tertiary alarms. The front door is supervised 12 hours per day and also alarmed with two different types of alarms, one requiring a code and one requiring a

key to shut off the alarm when responding to it. Upon the departure of the door supervision staff, the front door alarms are activated, with the exception of the Wanderguard alarm system which is kept activated 24 hours a day despite door supervision.

The facility is equipped with a Wanderguard alarm system on all external doors. The residents identified as wanderers wear a Wanderguard bracelet.

A Door Guard Stop Banner with Alarm has been placed on the doors at the top of the stairwell and at the bottom of the stairwell. This provides the doors with double alarms as well as a visual deterrent.

Facility standard implemented and educated for staff and residents to only use the stairwell doors for emergencies.

Facility staff were re-educated on the facility elopement policies.

A Wandering Resident policy has been developed with facility staff being educated including supervision of residents who are identified as wanderers or have increased supervision of needs.

The facility has developed and implemented an Exit Seeking system that identifies residents who have increased risk for wandering and elopement. The system provides a current list of identified residents readily available to all departments at different locations throughout the facility.

The Elopement Risk assessment was reviewed and revised to include wandering. All residents were reassessed with the revised assessment and care plans were updated accordingly. The Elopement/Wandering Risk Assessment will be completed upon admission, quarterly, and with any significant change in status.

4. ***How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?***

Administrator and/or Designee will conduct random observation to assure stairwell doors and stairwell alarm functionality testing is complete 3 times per week for 12 weeks.

Administrator and/or Designee will conduct weekly checks on all exterior doors and alarms for functionality 3 times per week for 12 weeks then weekly per standard protocol.

Administrator and/or Designee will perform random observation of Door Guard Banner placement and double door closure compliance 3X per week times 12 weeks.

The Social Service Director and/or Designee will perform random chart reviews of at least one resident identified at risk for wandering/elopement weekly for 12 weeks to assure care plan interventions, assessment, and supervision compliance is maintained.

Results of the reviews along with identified at risk residents will be discussed in the Quarterly QA meeting times 3 Quarters with educational needs discussed as needed.

COMPLETION DATE: **April 15, 1015** accepted

Attachment B
Imposed Plan of Correction