

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003255	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/09/2022
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NAME OF PROVIDER OR SUPPLIER HELIA SOUTHBELT HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH BELT WEST BELLEVILLE, IL 62220
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(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 Investigation of Facility Reported Incident of October 19, 2022/IL152958	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 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	S9999	Attachment A Statement of Licensure Violations	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	<p>Continued From page 1</p> <p>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.</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>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:</p> <p>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.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to implement safety measures for falls for one of three residents (R4) reviewed for falls in the sample of nine.</p> <p>Findings Include:</p> <p>R4's Care Plan, dated 10/23/22 documents, R4 is limited in physical mobility. R4 is unable to independently change position, while in bed as evidenced by not being able to turn, sit up, or move to the head of the bed. R4 is at risk for falls related to mobility.</p>	S9999		

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S9999	<p>Continued From page 2</p> <p>R4's Fall Risk Assessment, dated 10/20/22, documents she is at high risk for falls.</p> <p>R4's Nurses Note from Event Report, dated 10/19/22 at 4:49 PM, documents that "resident (R4) had witnessed fall out of bed, V6 (Certified Nursing Assistant/CNA) was changing her, and resident, R4, rolled out of bed and fell to the floor hitting her head. Resident, R4, was sent to a (local hospital), POA (Power of Attorney), and MD (Medical Doctor) was notified. VS (vital signs), prior to leaving 97.8, 93, 18, 132/77, 94%."</p> <p>R4's Nurses Note, from Event Report, dated 10/19/22 11:09 PM, documents "Resident, R4, returned from a (local hospital), ER (Emergency Room), with 11 sutures in-tact to forehead with bruising noted to both eyes. Resident, R4, transferred to bed with assist x (times) 4. Bed rails up and call light within reach, resident, R4, denies pain at this time."</p> <p>R4's Nurse Practitioner Note, dated 10/20/22, documents "patient, R4, was seen today for readmission. Patient, R4, had a fall out of bed on 10/19/2022, that resulted in an ED, (Emergency Department) visit, and 11 sutures into the middle of the forehead. Bruising noted around both eyes. Patient, R4, is alert and awake. Patient states she is having a little bit of pain all over, Tylenol as needed, made nursing aware. Records requested from ED visit. Not available for review at this time.</p> <p>On 11/2/22 at 1:13 PM, R4 refused to be transferred or gotten out of bed. R4 did have bed rails on her bed.</p> <p>On 11/3/22 at 8:32 AM, V6 (CNA) stated, "her (R4) bed didn't have bed rails, and she needed cleaning up. I went to turn her, R4, and she kept</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>rolling and rolled off the bed onto the floor. It was a regular bed with a remote. She, R4, was a two-assist, but I tried to do her myself."</p> <p>On 11/3/22 8:40 AM, V7 (Licensed Practical Nurse/LPN) stated, this was a week or two ago. "Well, she rolled out of the bed and fell." I had to send her out to the hospital, she hit her head. Her room was recently changed when she came back from the hospital. The rails were on order for her bed.</p> <p>On 11/3/22 1:42 PM, V18 (Nurse Practitioner/NP), stated "R4, fell from the bed. It could have been easily prevented with side rails on the bed. She was placed in a new bed without side rails."</p> <p>The policy, entitled "Falls Management," dated 7/2017, documents It is the policy of facility to assess and manage resident falls through prevention, investigation, and implementation and evaluation of interventions. The definition of a fall refers to unintentionally coming to rest on the ground, floor, or other lower level.</p> <p>(B)</p>	S9999		