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 07/13/2023

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

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S 000	Initial Comments Complaint Investigations: 2345541/IL161705	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.2420j) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 care and personal care shall be provided to each 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. Section 300.2420 Equipment and Supplies j) There shall be a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures. This shall include at a minimum the following: wheelchairs with brakes, walkers, metal bedside rails, bedpans, urinals, emesis basins, wash basins, footstools, metal commodes, over the lap tables, foot cradles, footboards, under the mattress bed boards, trapeze frames, transfer boards, parallel bars and reciprocal pulleys. These requirements are not meet as evidenced: Based on interview, observation, and record review, the facility failed to assure bed rails were securely attached to the bed frame to maintain resident safety for 3 of 5 residents (R4, R7, R8) reviewed for resident safety in the sample of 16. This failure resulted in R4's bed rail falling off and R4 sustaining a fall out of bed with multiple facial fractures and being hospitalized.	S9999		

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S9999	Continued From page 2 Findings include: 1. R4's Admission Record, undated, documents R4 was admitted to the facility on 6/27/23 and was discharged to the hospital on 6/29/23. R4's Electronic Medical Record documents R4's Diagnosis include Emphysema, Morbid Obesity, Type 2 Diabetes Mellitus, (DM), Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, (COPD), Osteoarthritis, Intestinal obstruction, Cognitive Communication Deficit, Dysphagia, Major Depressive Disorder, End Stage Renal Disease (ESRD)/chronic kidney disease, (CKD), Renal Dialysis, Malignant Neoplasm of Rectum, Fibromyalgia, Mixed incontinence, Hypertension, (HTN), and Hyperlipidemia. R4's Baseline Care Plan, dated 6/28/23, documents, "(R4) is at risk for falls. Interventions: call light within reach, provide clutter-free environment, encourage use of assistive device, provide proper, well-maintained footwear." R4's Care Plan, dated 6/30/23, documents, entered 7/7/23: "(R4) is at risk for falls related to, impaired mobility, poor safety awareness and DX, (diagnosis): DM II, Osteoarthritis, and HTN. Interventions: 6/29/23 Facility side rail audit completed. Educate resident on using call light to ask for help, encourage appropriate use of assistive device, evaluate multiple falls to determine commonalities or patterns, fall risk assessment quarterly and as needed, keep frequently used items within reach, promote placement of call light within reach and assess resident's ability to use, provide proper, well-maintained footwear."	S9999		

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S9999	Continued From page 3	S9999		

R4's Minimum Data Set, (MDS), dated 6/29/23, documents, R4 was cognitively intact with a Basic Interview for Mental Status, (BIMS), of 14. R4 required extensive assistance of one staff person for bed mobility, toilet use, transfers, and locomotion. R4 was occasionally incontinent of urine and has a colostomy.

R4's Fall Risk Evaluation, dated 6/27/23 at 4:54 PM, documents, R4 was a High Risk for falls with a score of 11. Scoring a 10 or higher makes resident "High Risk" for Falls.

R4's Nurses Note, dated 6/29/23 at 5:24 AM, documents "Staff completed rounds this nurse and CNA, (Certified Nursing Assistant), were in hallway and heard resident yelling for help. Upon entering room res, (resident), found lying face first on the floor on top of her right-side rail. Res stated, "I tried to roll over in bed." Res complaining of bilat (bilateral) hip pain and has small abrasion to middle of forehead. Res made comfortable until EMS, (Emergency Medical Service), arrived. Res assisted from floor to stretcher via (full body mechanical lift). Call placed to responsible party (V12) -no answer, voicemail left to call facility at earliest convenience. Call placed to Dr., (Doctor), (V16) - voicemail left. Nurse manager made aware. Res alert and oriented, able to make needs known, continues on 3 L, (liters), 02, (oxygen). Transferred to (Local Hospital), ER, (Emergency Room), for treatment and eval. VS, (vital signs), as follows 170/78-98-18-92%."

R4's Nurses Note, dated 6/29/23 at 8:57 AM, documents, "This nurse called for update on resident spoke with ER Nurse who is currently taking care of resident and was told resident has

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S9999	Continued From page 4 several fractures to whole face and currently awaiting results from CT, (cat scan), full body scan and will be transferred to (Regional Hospital), for further evaluation and treatment. All parties notified." On 7/10/23 at 9:00 AM, R5 (R4's Roommate) stated, "The nurse had just come in that night to check on us and shortly after she left, I heard a big bang and it sounded like the bedrail fell off, then I heard (R4) yelling for help. I couldn't see anything because, of the wall between us. I heard the staff tell the ambulance guys that the bed rail fell off the bed. They were going to put another resident in that bed but, that resident wanted a warmer room, so they switched to a different room. I don't think they should use that bed until it is fixed." On 7/10/23 at 9:05 AM, Room 110-1, R4's bed, is currently empty. The bed appears to be an older bed with an air mattress on the bed frame. There is only one side rail on the left-side of the bed (while lying in the bed), which is a metal rail with seven metal bars vertical on the rail. The bed rail is only secured by a black hand-turn knob that secures it to the bed by tightening it to the bedframe. The right-side bed rail is not on the bed. On 7/10/23 at 9:20 AM, V9, Maintenance Director, stated, "If there is something that needs fixed in the facility, the staff can put it into the computer system and that will make a work order for me to do. I will usually send (V10, Maintenance Worker) to fix it. I don't recall any requests for bed rails to be fixed. We have a group text that sometimes, they use to put in a request for something to be fixed, but I don't see anything in the group text about bed rails. I did	S9999		

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

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S9999	Continued From page 5	S9999		

have a request on 6/21/23, to remove the bed from 110-1 to room 201, so that was done. I never know why; I just do what the work order says. We do inspections every week to all beds in the facility. We look at the power to the bed, the bed deflate/inflate as needed, and the bed rails to make sure they are secured. I don't really have a record of those inspections except for my last one on 6/29/23 after (R4) fell."

On 7/10/23 at 9:25 AM, V10, Maintenance Worker, stated, "There are a lot of times that the staff will catch me in the hallway and ask us to fix something and a work order isn't really done, we just go in and do it. I remember someone grabbed me one day and said that room 110-1 needed a new bed rail for the resident to use as a support rail for turning. I made sure that the rails were secured to the bed before I left. I guess the only way a bed rail would fall off is if it wasn't put on properly or sometimes the resident uses it so much that it becomes loose."

On 7/10/23 at 11:42 AM, V11, Social Worker at (Regional Hospital), stated, "I'm the Social Worker helping (R4) and her husband at the hospital. They did not want to report it themselves because they felt they would have backlash. What they told me was that (R4) was admitted to the facility and immediately upon admission to her bed, she told the staff that her bed rail was loose and wiggly. They stated that they made it very clear to several staff members that it needed fixed, and no one did anything about it. (R4) stated, that while she was trying to reposition in bed, the bed rail fell off and she fell to the floor. (R4) is still in the ICU with multiple facial fractures and they are refusing to go back to that facility."

On 7/10/23 at 11:49 AM, V12, R4's Husband,

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S9999	Continued From page 6	S9999		

stated "My wife (R4) got to the facility and upon putting her in her bed, she noticed that her bed rail was very loose and wiggly. She told and showed them how loose it was, and no one did anything to fix it. She was only there about a day or so, and I believe it was the nurse who called me around 4:00 AM and told me that my wife's bed rail fell off and she fell out of bed and was going to (Regional Hospital). They x-rayed just about everything, and it looks like she only has facial fractures. (R4) said it was the nurse who was working with her upon admission that she talked to about the bed rail. I went into the facility after she fell to collect all her belongings, and when I got to her room, they still had the same bed there with the rail sitting on the bed. I got down on the floor to look at how the rails are attached to the bed, and it is only attached by a hand knob that you hand tighten. All anyone had to do was to tighten the black knob and my wife would not be in this condition. Anyone could have done that. Their negligence is why my wife is like she is now."

On 7/10/23 at 12:52 PM, V13, RN (Registered Nurse), stated, "I was the one who admitted (R4). I am new to the facility and remember that I was very focused on the computer and my documentation. I vaguely remember someone in the room saying something about a bed rail, but without making something up or lying about it, that is about all I remember. When I came back to work, I heard that she fell out of bed."

On 7/10/23 at 1:05 PM, Room 201-1's bed is empty, made up and ready for a new resident. The bed appears to have the same bed rails as R4's bed. Upon examination of the bed rails, both side rails have the same black hand turn knob that attaches it to the bed frame, and when

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S9999	Continued From page 7 examined, both knobs were loose and easily turned. On 7/12/23 at 10:45 AM, V20, CNA Supervisor, stated, "I told the nurse the day before she fell that (R4) was leaning on that bed rail." The facility's Fall Investigation dated 6/29/23 at 4:45 AM, documents, "Incident Description: Staff completed rounds at 4:45 AM, resident repositioned in bed and peri-care completed. This nurse and CNA, (Certified Nursing Assistant), were in hallway and heard a loud noise, heard resident screaming for help. Upon entering room, resident was laying face first on the floor on top of side rail. Resident has small abrasion to forehead and complaining of bilat hip pain. Resident stated, "I was trying to turn over in bed." Predisposing Environmental Factors: Safety Device. Predisposing Situation Factors: Side Rails Up." The Facility's "Sentinel Call Worksheet" dated 6/29/23 at 9:30 AM, documents, the date of incident: 6/29/23, the time of incident: 5:15 AM, the location: Resident's Room. What occurred: Resident Rolled out of bed and rail came off. How it Occurred: The Railing came off the bed. Staff training - immediate needs? The whole house side rail audit was done. The Facility's "Post Fall Huddle", dated 6/29/23 at 5:15 AM, documents, "What did the resident say he/she was trying to do just before the fall? Rolled over. What appears to be the initial root cause of the fall? Rolled out of bed. Side rail off. Conclusion: Resident rolled out of bed." The Facility's "Follow-Up Investigation Report", dated 7/6/23, documents R4 has frontal sinus facial fracture, mildly compressed skull fx,	S9999		

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S9999	Continued From page 8	S9999		

(fracture), with possible subdural hematoma. Interview of alleged victim: Resident (R4) reported she rolled out of bed repositioning herself. Medical record review: Resident is alert and oriented X 3 and was able to make all needs known. Transfer status assist of X 2 for ADLs (Activities of Daily Living) and transfers. Resident is continent of bowel and bladder. Conclusion page: Unsubstantiated. Conclusion: Following a complete and thorough review including interviews and resident record, this occurrence was determined to be unavoidable. Root cause analysis: Resident attempted to turn and reposition without assistance and fell off the bed onto the floor. This allegation cannot be substantiated." (Completed by V2, Director of Nursing/DON)

The Facility's Side Rail Audit, completed by V9, dated 6/29/23, documents Room 110-1 "Bed 1 empty bed with BW, (black and white), rail regular, Bed 2 hospital bed."

R4's (Local Hospital) Emergency Room record, dated 6/29/23, documents "Pt., (patient), arrives in ED, (Emergency Department), via EMS from, (Facility), SNF, (Skilled Nursing Facility), c/o, (complaint of), bilateral hip pain s/p, (status post), fall. Pt. AO, (alert and oriented), X 4 and in NAD, (no added distress). Per EMS pt was being moved or turned at SNF and one of the bed rails gave way and she fell from the bed to the floor." A CT, (cat scan), of R4's Cervical Spine, Thoracic and Lumbar Spine, Abdomen/Pelvis, Facial Bones, and Head were completed with R4's CT Results: "Mildly depressed fracture of the left frontal bone involving the left frontal sinus. Subtle increased density along the left anterior cranial fossa deep to the site of fracture. This is non-specific for a tiny subdural hemorrhage." R4

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S9999	Continued From page 9 was transferred to, (Regional Hospital), Geriatric Trauma Team. R4's (Regional Hospital) Emergency Room record, dated 6/29/23, documents, "Female transfer from, (Local Hospital), following fall. Per EMS, pt. was being turned by staff at facility when the side railing of her bed broke off and pt. fell out of bed flat onto her front side. OSH (outside hospital) imaging showed several facial fx, (fractures), as well as possible underlying SDH, (subdural hematoma/hemorrhage)." 2. R7's Admission Record, undated, documents R7 was admitted to the facility on 8/27/20. R7's Electronic Medical Record, documents R7's Diagnosis include Cerebrovascular Accident, (CVA), Hemiplegia/Hemiparesis, Dysphagia, Morbid Obesity, DM, Visuospatial Deficit, Frontal lobe and Executive function deficit, Cognitive social or emotional deficit, Attention and concentration deficit, Anemia, ESRD/CKD, Dialysis, Anxiety disorder, HTN, Hyperlipidemia. R7's Care Plan, dated 6/6/23, documents, "(R7) requires healthcare monitoring related to DX: CVA with Hemiparesis. She is at risk for impaired mobility and impaired communication related to effects of hemisphere damage on language or speech." It continues "(R7) is at high risk for falls r/t, (related to), weakness d/t, (due to), hx, (history), /dx of CVA with hemiplegia, Dysphagia, Morbid Obesity, DM, CCD, (cognitive communication deficit), Osteomyelitis, Anxiety, HTN, Hyperlipidemia, ESRD and Anemia. Resident is an extensive assistance of two staff members for bed mobility. Resident is a total assistance of two staff members for toileting and transfers. Resident has weakness present.	S9999		

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S9999	Continued From page 10 Resident utilizes Geri-chair. Interventions: 6/5/21 Bed moved against wall, fall mats placed by bed, fall risk assessment quarterly and as needed, promote placement of call light within reach and assess resident's ability to use." It continues "(R7) has a self-care deficit in bed mobility r/t weakness and decreased mobility. Interventions: 2. Instruct and assist to cross leg over other towards the side turning to. 3.instruct to look towards the rail of the side turning to. 4.instuct to roll shoulders toward the side turning to. 5.Instruct to reach/grasp for rail of side turning to. 6. Instruct and assist to pull self toward side turning to." It continues "(R7) requires assist with daily care needs r/t weakness d/t hx/dx of CVA with hemi, Dysphagia, Morbid Obesity, DM, CCD, Osteomyelitis, Anxiety, HTN, Hyperlipidemia, ESRD and Anemia. Resident is an extensive assistance of two staff members for bed mobility. Resident is a total assistance of two staff members for toileting and transfers. Resident has a (urinary catheter) and functional incontinence of bowel. Resident has a G (gastric)-tube present is NPO, (nothing by mouth). Resident is a total assistance of one staff member for meals. Resident has weakness present. Resident utilizes Geri-chair. She utilizes 1/2 side rails up X 2 to enhance mobility and transfer. Interventions: (full body mechanical lift), with two assists for transfers." R7's MDS, dated 6/15/23, documents, R7 has a moderate cognitive impairment with a BIMS of 12. R7 requires total dependence on two staff members for transfers, toilet use, and bathing. R7 requires extensive assistance from one to two staff members for all other ADLs. R7 is always incontinent of urine and frequently incontinent of bowel.	S9999		

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S9999	Continued From page 11 R7's Physician Order, dated 7/10/23, documents, "1/2 Side rails up X 2 to enhance mobility and transfer." R7's Fall Risk Evaluation, dated 9/15/22, documents, R7 was a High Risk for falls with a score of 11. Scoring a 10 or higher makes resident "High Risk" for falls. On 7/10/23 at 1:38 PM, R7 was seen sitting in a recliner chair by her bed. R7 has the same bed rails as R4's bed had, and upon examination, the black hand turn knob on the right-side rail was loose and easily turned. The left side rail was against the wall and could not be examined. R7 stated that her rail is a little wobbly but has never fallen off. 3. R8's Admission Record, undated, documents R8 was admitted to the facility on 4/15/23. R8's Electronic Medical Record, documents, R8's diagnosis include: CVA, Hemiplegia/Hemiparesis, Acute/Chronic Respiratory Failure, Type 2 DM, Aphasia, Dysphagia, Anemia, ESRD/CKD, Gastrostomy, HTN, Deep Vein Thrombosis, (DVT), and Dependence on Renal Dialysis. R8's Care Plan, dated 4/18/23, documents "(R8) is at risk for developing an impairment in functional joint mobility/ (R8) has impaired functional mobility/ (R8) has contractures noted to (specify), r/t: weakness/ discomfort when moving/ spasm of affected area/ poor motivation/ inactivity resulting from impaired cognition/ inactivity resulting from (specify)/ neurological deficit." R8's MDS, dated 6/15/23, documents, R8 has a severe cognitive impairment and requires total dependence for all his ADLs. R8 is always	S9999		

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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
S9999	Continued From page 12	S9999		

incontinent of both bowel and bladder.

R8's Fall Risk Evaluation, dated 6/27/23, documents, R8 is a High Fall Risk with a score of 13. Scoring a 10 or higher makes resident "High Risk" for falls.

On 7/10/23 at 1:35 PM, R8 was seen lying in his bed with the same bed rails as R4's bed. Upon examination of the rails, both side rails had the black hand turn knob which was loose and easily turned. The rails appeared to be wobbly. R8 was not able to communicate.

On 7/11/23 at 12:00 PM, V17, Regional Director of Operations, stated, "I went and looked at the rooms you mentioned that had loose bed rails and I only found one of them, in room 217-2 (R8's bed), that was loose. Someone must have tightened the other two. I have our maintenance guys going room to room and tightening all the bed rails."

On 7/13/23 at 8:55 AM, V1, Administrator, stated, "Anytime a staff member is notified or sees something that is broke, or in need of repair, I would expect them to report it to maintenance immediately. I would expect maintenance to make the repair as soon as possible."

The Facility's "Fall Prevention and Management" Policy, dated 9/2022, 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

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 07/13/2023

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S9999	Continued From page 13	S9999		

modified as needed. 1. A fall risk evaluation will be completed on admission, readmission, and quarterly, significant change and after each fall. 2. Residents at risk for falls will have fall risk identified on the interim plan of care and the ISP with interventions implemented to minimize fall risk.

The Facility's "Use of Bed Rail" Policy, dated 10/2022, documents, "It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. "Bed Rails" are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars. 6. The facility will assure the correct installation and maintenance of bed rails, prior to use. This includes a. Checking with the manufacturer(s) to make sure the bed rails, mattress, and bed frame are compatible. b. Ensuring that the bed's dimensions are appropriate for the resident by: i. Confirming that the bed rails are appropriate for the size and weight of the resident using the bed; ii. Installing bed rails using the manufacturer's instructions and specifications to ensure a proper fit; iii. Inspecting and regularly checking the mattress and bed rails for areas of possible entrapment; iv. Ensuring the bed frame, bed rail and mattress do not leave a gap wide enough to entrap a resident's head or body, regardless of

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S9999	Continued From page 14 mattress width, length, and/or depth. v. Checking bed rails regularly to make sure they are still installed correctly and have not shifted or loosened over time. c. Conducting routine preventative maintenance of beds and bed rails to ensure they meet current safety standards and are not in need of repair. 8. Responsibilities of ongoing monitoring and supervision are specified as follows: d. The maintenance director, or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails." (A)	S9999		