Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057521	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLEVILLE HEALTHCARE CENTER	**727 NORTH 17TH STREET , BELLEVILLE, Illinois, 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) COMPLETION DATE
S0000	Initial Comments Complaint #2545251/IL194363	S0000		
S9999	Final Observations Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. This Requirement is NOT MET as evidence by: Findings include:	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 Based on interview and record review the Facility failed to ensure a written report of resident eloping who required emergency hospitalization for 1 of 6 residents (R2) reviewed for elopement in the sample of 11. R2's Nurse's Notes dated 6/10/2025 at 6:43 AM, "Resident left out of facility back door. Writer was notified at 6:23 AM. Resident was found in shed on property yard at 6:30 AM. Brought resident back to facility via walking with staff. Resident has a history of elopement and is being sent to hospital for evaluation." (Author V9, Licensed Practical Nurse (LPN). R2's EMS (Emergency Medical Services) report dated 6/10/2025 at 8:04 AM, "EMS dispatched to (facility) for a 72-year-old male with behavioral and elopement issues. Upon arrival nurse gave a brief report stating the patient is alert x 4. The patient has a history of paranoid schizophrenia, HTN (High blood pressure) and anemia. Upon arrival patient was found standing in the hallway and initial assessment was done and patient was found to be alert and orientated x 4. Patient self-walked to the cot where he was then secured to the cot with the safety belt and side rails. Once in the ambulance a second set of vitals were obtained as well as a signature from the patient." R2's Hospital Record dated 6/10/2025 at 8:37 AM, document, "72-year-old male history of dementia, schizophrenia, who was brought to the emergency room from a psychiatric facility for psychiatric evaluation. Patient is poor historian; all information was obtained from EMS per facility report. Patient, per report, has been agitated, had multiple attempts this week to elope, patient denies any suicidal or homicidal ideation, being compliant with his medications. Patient is alert and orientated x 2, his judgement and insight are limited. He is paranoid and guarded. He is irritable and labile. Certified Medical Emergency, Patient's condition represents a Certified Medical Emergency. Hospitalization required. Diagnosis dementia in other diseases classified elsewhere with behavioral disturbances. R2's Hospital Psych Discharge Notes dated 6/16/2025 documents, "Reason for admission and hospital course. Patient was a resident at the nursing home. He was sent	S9999		

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S9999	Continued from page 2 to the hospital because of increased paranoia and agitated behavior. Patient was admitted to the closed psych unit. He was started on medication. His medications were adjusted. He was provided educations supportive therapy." On 6/25/2025 at 2:45 PM, no initial report was submitted to the State Agency for the elopement of R2. On 6/25/2025 at 2:48 PM, No final report was submitted to the State Agency regarding the elopement of R2 on 6/10/2025 and R2 being hospitalized for six days. On 6/25/2025 at 2:49 PM, V1, Administrator stated he was not sure if this was reported to the State. On 6/25/2025 at 2:51 PM, V10, Regional Nurse Consultant (RNC) stated this was not reported because they did not feel it was an accident/incident or that his hospital stay was caused by him eloping or any serious harm occurred. The Facility Elopement Policy with a review date of 9/2022 document, "Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. This does not include alert and oriented residents who handle themselves outside the facility and choose to leave the facility, even if against medical advice. While presenting different care challenges, these alert residents are not in the same category of potential danger as the residents with impaired cognition trying to leave the facility, and their absences from the facility are not considered to be an elopement." B	S9999		