

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>ASL5108136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/16/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>REVELA AT O'FALLON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1022 EAST WESLEY DRIVE O FALLON, IL 62269</b>
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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
A 000	Initial Comment  Annual Licensure Survey  Violations cited: Section 295.2040 Disaster Preparedness	A 000		
A2040	Section 295.2040 Disaster Preparedness  This RULE: is not met as evidenced by: TYPE 3 VIOLATION  Section 295.2040 Disaster Preparedness  5) Orient each resident to the emergency and evacuation plans within 10 days after the resident's arrival. Orientation shall include assisting residents in identifying and using emergency exits. Documentation of the orientation shall be signed and dated by the resident or the resident's representative.  Based on record review and interview, the Establishment failed to ensure the residents received an orientation within ten days of admission to the Establishment.  During record review, the Establishment could not reproduce any evidence that the residents received an orientation to the Establishment's building.  During interview with E1, Executive Director, on 08/16/24, E1 confirmed he was unable to reproduce a thorough resident orientation for review.	A2040		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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