STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145290	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belleville Healthcare Center	727 North 17th Street Belleville, IL 62226

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34964 Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse by an employee for 1 of 5 residents (R28) reviewed for abuse in the sample of 29. Findings include: The facility's Initial Report of Abuse dated 5/11/24 at 2:50 PM documents, IDPH (Illinois Department of Public Health) was notified that employee (V23, Certified Nursing Assistant (CNA)) called resident (R28) a name, cripple a**. Another resident reported this to the nursing aide supervisor. This employee then reported the allegation to the staffing coordinator who then notified the Administrator. The facility's Final Report of Abuse dated 5/15/24 at 1:30 PM documents, Interview of alleged perpetrator: She (V23) wrote a statement that the resident (R28) was yelling and cursing at her, and she instructed him to put an ice scoop in the proper place at which time he continued to call her names and curse. She stated she started mumbling to herself. She also stated to the nursing supervisor at the time of the incident that she did curse, but that she did so in a low voice so that no one could hear her. The Final Report of Abuse further documents, Interview of witnesses: Interviews with witnesses confirm that the accused employee did yell and curse at the victim. Statements from fell ow resident and several staff members were attained and documented. The report documented the conclusion of the investigation based on findings: As a result of interviews and statements from witnesses to the incident, the allegation was substantiated based on findings resulting from the investigation. As a result, the alleged perpetrator has been terminated from employment permanently. R28's Face Sheet documents his diagnoses to include Schizophrenia, Asthma, Seizure Disorder and Anxiety. R28's Minimum Data Set (MDS) dated [DATE] documents he is moderately cognitively impaired. It also documents he requires supervision with his Activities of Daily Living (ADLs). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. 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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R28's Care Plan dated 6/26/24 documents, (R28) is at risk for abuse and/or neglect related to history of verbal and physical aggression, social isolation, sexually inappropriate behaviors, has a history of misusing 911 when delusional, receiving psychotropic medications and DX (diagnosis): Schizophrenia and Mild Intellectual Disability. The goal for this care plan is: (R28) will not be abused and/or neglected thru next review date. Interventions for this care plan include: 5/11/24 staff member suspended pending investigation, resident assessed, (local police department) called Psychosocial F/u (follow-up) to continue.; If resident becomes difficult during care, make sure resident is safe and walk away. Allow resident time to calm down, then reapproach.; Keep resident safe from harm at all times; and Staff to provide education/counseling if behaviors are noted. On 6/27/24 at 8:30 AM R28 stated he did not remember any incidents with any CNA and the ice chest. On 6/27/24 at 9:32 AM V1, Administrator, stated another resident, R30, reported to the CNA Coordinator, V26, that V23 had cursed at R28 about the ice chest, and she notified V1. He stated he did the investigation, and it was substantiated, and he terminated V23. V1 stated he reported the allegation of abuse to IDPH immediately but did not report it to the Department of Professional Regulations because he followed the facility's policy, and it is not mandated that he report to the Department of Professional Regulations. On 6/27/24 at 9:45 AM V25, Housekeeper, stated he witnessed V23 yelling at R28 by the ice chest, telling him the ice scoop should not be left in the ice. V25 stated he heard R28 call V23 a bitch and she called him a bitch back and also told him he was a cripple a**. V25 stated he could see R28 was about to hit V23, so he intervened and got R28 to go down to his room and calm down. V25 stated V23 continued to curse as R28 was walking away. V25 stated he reported the incident to the nurse on duty, but by the time she went to report it to the Administrator, another resident, (R30), who had also witnessed the incident, had gone up and reported it to another staff. V25 stated he took the trash out and by the time he came back in, they were escorting V23 out of the facility. V25 stated he did not know V23 very well and had just seen her working there from time to time and stated he had never witnessed her being abusive to any other residents. On 6/27/24 at 9:50 AM V26, CNA stated she had been the CNA Coordinator at the time of the incident between V23 and R28. She stated it happened downstairs and she was working upstairs when another resident, (R30), came up and told her, (V23) is down there cussing out (R28). She stated she went down to see what was going on and she asked V23 if she had cussed at R28 and V23 stated to her that she had cussed him out to herself and that nobody else had heard her. V26 stated she informed V23 that others, including staff and residents, had heard her cussing and that it was not appropriate, and she could not talk to residents that way. V26 stated V23 stated she hears cussing in the facility all the time. V26 stated she told V23 again that it is not ok to cuss at residents and then she told her, You have to leave the facility right now. V26 stated after V23 left the facility, she reported the incident to V1, and he started his investigation. On 6/27/24 at 10:15 AM R30, (MDS 5/3/24 documents he is alert and oriented) stated he saw the CNA cussing at R28 because he didn't put the ice scoop back in the holder, so he went upstairs and told (V26) about it and she went right down to take care of it. R30 stated he had not seen V23 yell or curse at anyone else. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy, Abuse Policy and Prevention Program dated 10/2022 documents, The facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff, and mistreatment of residents.