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	08/29/2024

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49494 Based on interview, observation, and record review the facility failed to ensure wound treatments were consistently provided for 1 of 3 residents (R2) reviewed for wound care. This failure resulted in R2 requiring transfer to the hospital, maggots developing in R2's wound, a diagnosis of osteomyelitis and needing IV antibiotics therapy. Findings include: R2's face sheet, dated 8/28/24, documented R2 has diagnoses of unspecified open wound on right lower leg, osteomyelitis, local infection of the skin and subcutaneous tissue, type 2 diabetes, bipolar disorder, coronary angioplasty implant and graft, traumatic compartment syndrome of right lower extremity, hypertension, and depression. R2's MDS (Minimum Data Set), dated 7/29/24, documented R2 is cognitively intact. R2's MDS, dated [DATE], documented R2 has not exhibited any rejection of care behaviors. R2's MDS, dated [DATE], documented R2 has not exhibited any rejection of care behaviors. R2's weekly skin assessment of right lower leg wound, dated 8/14/24, documented surgical wound with delayed closure wound. Wound has moderate serosanguinous drainage present. Wound bed appearance is red with 80% granulation and 20% slough. Wound edges are attached. Peri wound is fragile and red. Wound is undermining 0.3 cm from 12 o'clock to 2 o'clock. Zero odor observed. Zero complaint of pain voiced. R2's TAR (Treatment Administration Record), dated August 2024, documented an order for xeroform petrolatum dressing to right lateral calf topically one time a day every Monday, Wednesday, and Friday to promote wound healing with a /start date of 8/16/24 and discontinue date of 8/19/24. R2's TAR documented wound care was completed on 8/16/24, however the facility was unable to provide documentation of when the treatment was signed off since V16, Licensed Practical Nurse (LPN) in an interview stated the treatment was not signed off on 8/16/24 when she worked on 8/18/24. R2's progress note, dated 8/18/24 at 10:37 am, documented another resident came to the nursing station being very aggressive toward this nurse demanding that resident's dressing be changed daily. R2 has an order for the dressing to be changed Monday, Wednesday, and Friday. This nurse and another staff went to observe the resident. This nurse removed the ace wrap and inspected the dressing. The dressing is securely intact and dry. The resident was educated on the importance of keeping the dressing intact and covered for the number of days in order to promote wound healing. (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R2's progress note, dated 8/19/24 at 5:55 am, documented nurse was called to resident room by CNA to assess resident; maggots were found in the sheets; upon further investigation, nurse found a maggot on resident dressing on RLE (right lower extremity), dressing was then unwrapped and found maggots within wound bed; on call MD (Medical Doctor) made aware, order to send to ED (Emergency Department) for eval (evaluation) and tx (treatment). Wound was then cleaned with wound cleanser per order and wrapped with kerlix. EMS (Emergency Medical Service) was called for transport to local hospital. R2's local hospital progress note, dated 8/19/24, documented R2 presented to the ED with complaint of worsening pain to RLE wound and maggots in wound. She states dressing is to be changed every MWF (Monday, Wednesday, Friday), but staff hadn't changed since last Wednesday. Maggots were noted in her wound this morning, so she was brought to the ED for further evaluation. It continues, Patient to be admitted for further evaluation and management of acute on chronic OM (osteomyelitis) as well as vascular and ID (Infectious Disease) consultations. R2's local hospital progress note, dated 8/19/24, documented XR (x-ray) of tibia and fibula date of service 8/19/24 at 7:52 am provided clinical information: [AGE] years, female, pain, this morning there were maggots found in her bed and when looking at her leg maggots were found there. Procedure and materials: AP (anterior to posterior) and lateral view of the right tibia and fibula. Comparison studies: April 23, 2024. Observations: there is a large soft tissue defect that is present about the lateral aspect of the right lower leg. Severe soft tissue swelling is present. The soft tissue swelling is increased compared to prior examination. The soft tissue defect now extends through to the underlying fibula. There are lucent areas that are present within the fibula concerning for areas of osteomyelitis. R2's local hospital progress note, dated 8/22/24, documented right leg wound culture positive for MRSA (methicillin-resistant staphylococcus aureus), pseudomonas aeruginosa, and proteus klebsiella. R2's re-admission orders to facility, dated 8/23/24, documented orders for cefepime 2 grams in sodium chloride IV (intravenous) every 12 hours for 42 days and vancomycin 1.5 grams IV daily for 42 days. On 8/27/24 at 4:25 pm R2 stated that the facility Wound Nurse V3 was on vacation the week that she developed the maggots in her leg wound. R2 stated that no staff changed nor offered to change her dressing on Friday, August 16, 2024. R2 stated that she could feel the maggots moving over the weekend and she asked a nurse to look at it, but none did. Observed many flies in resident's room during this interview. On 8/28/24 at 11:02 am R2 stated that the DON nor any nurse changed her dressing on 8/16/24. R2 stated that she tried to get her nurse to change the dressing over the weekend and that she even told the nurse that she had creepy crawlies in her leg. R2 stated that the leg wound was oozing, and her dressing was saturated. R2 stated that her nurse on Sunday, 8/18/24 was rude, rolled her eyes at her, and replied that is not my job in response to her complaint of feeling creepy crawlies in her leg and to her request of getting her wound looked at and her dressing changed. R2 stated that her nurse looked at her dressing but did not remove the dressing to assess the wound. R2 stated that her friend, R7, a fell ow resident, even tried to get the nurse to change her dressing to her leg but she still didn't get the wound assessed nor the dressing changed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/28/24 at 9:50 am V2 DON (Director of Nursing) stated that she changed R2's RLE dressing on 8/16/24 and that she did not observe any maggots on the wound at this time. V2 stated that R2 has a history of being noncompliant with dressing changes and with keeping the dressings on the wound but that the facility does not have any of this documented. V2 stated that she would have expected her nurse to remove the dressing and assess the wound when R2 complained of discomfort in her wound on 8/18/24. On 8/29/24 at 10:07 am V16 LPN (Licensed Practical Nurse) stated that she was R2's nurse on 8/18/24 and that another resident, R7, became verbally aggressive with her and stated that R2's dressing needed to be changed daily. V16 stated that she informed R7 that is a HIPPA issue. V16 stated that she looked at R2's TAR (Treatment Administration Record) and she saw that R2's dressing did not get changed on Friday, August 16, 2024, and that the TAR was red for that date because it was not completed. V16 stated the last time it had been signed off was on 8/14/24. V16 stated that R2 told her that her leg dressing had not been changed since Wednesday, August 14, 2024. V16 stated that she looked at the dressing but did not change it because R2 did not complain to her about any discomfort. On 8/28/24 at 12:45 pm R7 stated that on 8/18/24 around 8:45 am he went to R2's nurse and asked her to change R2's right leg dressing because the dressing was saturated and that R2 told him she was having discomfort and could feel something crawling in the wound. R7 stated that it was obvious that the dressing needed changed because he could see the drainage on the outside of the dressing. R7 stated that R2's nurse told him that he needed to mind his own business. R7 stated that he was outside of R2's room in the hallway at 10:30 am waiting in line to go out and smoke on that same day. R7 stated that he observed R2's nurse in her room looking at R2's leg dressing. R7 stated that he heard the nurse tell R2 it's not due to be changed until Monday, I am not changing it. R7 stated that the nurse slammed the door shut when she saw him looking at her. R7's MDS, dated [DATE], documented that R7 is cognitively intact. On 8/28/24 at 1:58 pm V2 DON stated that she gave R2 her personal cell phone number in case she ever has issues again with getting her dressing changed. V2 stated that R2 told her that the weekend nurse on 8/17/24 and 8/18/24 refused to assess her wound and change the dressing even after R2 informed the nurse that she felt something crawling on the wound. V2 stated that she will be providing 1:1 education with that nurse because that was not appropriate for her not to look at the wound. V2 stated that R2 was moved to a different room today because she had been in a room next to the exit door where the residents go out to smoke resulting in more flies in R2's previous room. The facility Skin Management: Monitoring of Wounds and Documentation policy, dated 1/2022, documented it is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility. Responsible party: All nursing staff. General guidelines: An evaluation of the PU/PI (pressure ulcer/pressure injury), if no dressing is present. An evaluation of the status of the dressing, if present (whether it is intact and whether drainage, if present, is or is not leaking); The status of the area surrounding the PU/PI. The presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection (for example: increased redness or swelling around the wound or increased drainage from the wound); and whether pain, if present, is being adequately controlled.