

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Belleville Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908</p> <p>Based on interviews and record reviews the facility failed to secure a resident's medication, for 1 out of 3 residents, (R2), reviewed for misappropriation of resident's property in a sample of 4.</p> <p>Findings include:</p> <p>R2 was admitted to the facility on [DATE] with diagnosis of, in part, hemiplegia affecting left nondominant side, low back pain, neuropathy and fibromyalgia.</p> <p>R2's Minimum Data Set (MDS) dated [DATE] documented R2 being cognitively intact.</p> <p>R2's Care Plan dated 8/27/24 documented R2 has an alteration in pain related to neuropathy, Fibromyalgia, with chronic pain/ low back pain. R2's Care Plan also included she is at risk for abuse and neglect.</p> <p>R2's Orders dated 9/14/24, upon return from the hospital, documented V8, Registered Nurse (RN), placed a new order for R2's prescribed Oxycodone at 4:36 PM and V15, Medical Director signed the order at 11:56 PM on 9/16/24. This order was for Oxycodone to be Given 10 mg by mouth every 4 hours as needed for pain.</p> <p>R2's Progress Notes dated 9/14/24-9/20/24 show no documentation of her Oxycodone being administered.</p> <p>R2's Medication Administration Record (MAR) for September 2024 documented no administration of her Oxycodone until 9/21/24.</p> <p>R2's Oxycodone Controlled Drug Receipt/Record/Disposition Forms received on 8/8/24, 8/23/24, and 9/17/24 are forms printed directly from the pharmacy. These forms included the prescription number, date received, doctor name, and pharmacy information at the top. The Controlled Drug Receipt/Record/Disposition Form dated 8/24/24-8/29/24, documented 16 tablets of R2's Oxycodone remaining on the last administration prior to her hospitalization on [DATE]. R2's Oxycodone Controlled Drug Receipt/Record/Disposition Form documenting the remaining 16 tablets was initially requested from V2 (DON) at 3:00 PM on 10/22/24 and provided at 8:20 AM on 10/23/24. This form was handwritten with no prescription number, date received, or pharmacy information, unlike all the other forms.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/22/24 at 9:45 AM, R2 stated she had been in the hospital and when she came back it took some time to get her pain medication in.</p> <p>On 10/23/24 at 1:40 PM, R2 stated it took days for the facility to supply her Oxycodone after returning from the hospital and she had to stay on their case to get it because her pain rating was over a 10/10.</p> <p>On 10/22/24, at 2:45 PM, V2 (DON) stated R2 did not have any of her prescribed narcotic pain medication left when she came back from the hospital.</p> <p>On 10/22/24, at 3:00 PM, V2 (DON) confirmed 16 of the prescribed narcotic pain medication tablets remained on R2's August Controlled Drug Receipt on 8/29/24. V2 stated, I do not know where the 16 pills are or where the rest of the sign out form is. I need to check and find out.</p> <p>On 10/23/24, at 8:20 AM, V2 (DON) supplied a handwritten Controlled Drug Receipt/Record/Disposition Form for R2's Oxycodone dated 9/14/24-9/22/24, the only form that was completely handwritten; not supplied by the pharmacy. V2 (DON) stated they had to hand write that one because the original form was removed when R2 left for the hospital. V2 (DON) stated we thought R2 was not coming back to the facility and her medication was removed prior to her coming back. V2 (DON) stated she did not know who wrote the form.</p> <p>On 10/23/24, at 9:30 AM, V8 (RN), stated she did not sign out the Oxycodone for the 15 out 16 of dates listed with her signature on R2's Controlled Drug Receipt/Record/Disposition Form dated 9/14/24-9/22/24. V8 (RN) stated she wouldn't have started a new sheet on a controlled substance either. V8 (RN) stated, I remember, V2 (DON) told me there was no Oxycodone available when R2 returned from the hospital on 9/14/24. I remember this because R2 made a big stink about her medication not being available. This makes me feel very uncomfortable someone would [NAME] my signature especially for a controlled substance. I have taken care of R2 for a couple years now and know her well. V8 (RN) stated she never gave R2 prescribed narcotic pain medication unless she requested it for pain and is very careful about supplying it to her.</p> <p>On 10/23/24, at 9:41 AM, V9, Pharmacy Representative, stated the facility's provider signed a new prescription for R2's prescribed narcotic pain medication on 9/16/24 and filled/delivered it on 9/17/24. The supply was for 60 pills to last 10 days.</p> <p>On 10/23/24 at 11:35 PM, V10, Licensed Practical Nurse (LPN), stated she witnessed V2 (DON) remove R2's remaining prescribed narcotic pain medication tablets from the medication cart while R2 was in the hospital. V10 (LPN) stated on 9/14/24 she and V8 (RN) went to V3, Assistant Director of Nursing (ADON), and told her that R2 was requesting her pain medication, and they could not find it in the cart. V10 (LPN) stated V3 (ADON) looked for the medication and said it was not there and could not find it.</p> <p>On 10/23/24 at 12:25 PM, V8 (RN) stated she had to contact the provider 9/14/24 to let them know R2 was completely out of her pain medication. V8 (RN) stated V2 (DON) had told her that the medication had been destroyed while she was at the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/23/24, at 12:44 PM, V11, [NAME] President of Clinical Reimbursement, was notified of the concern for theft of a narcotic. V11 stated they have put in a new protocol for the nurse managers to officially count all narcotics each morning.</p> <p>On 10/23/24 at 1:23 PM, V11 stated he is suspending V2 pending a drug diversion investigation.</p> <p>On 10/23/24 at 2:50 PM, V13 (LPN) stated the Oxycodone was not here when R2 returned from the hospital. V13 (LPN) stated he worked R2's hall on 9/15/24. V13 (LPN) stated he looked for the Oxycodone after R2 reported being in pain, but it wasn't in the medication cart, so he offered her the alternate pain medication available.</p> <p>On 10/24/24 at 8:35 AM, V15, Medical Director, stated he would expect meds to be given as ordered, would expect to be notified if a resident is out of medication and would expect staff to refill medications in a timeframe that residents don't have to go without it.</p> <p>The facility's Abuse Policy and Prevention Program 2022 documented the facility affirms the right of its residents to be free from misappropriation of property. The facility's Narcotic Medication Policy documented the responsible party appointed to provide guidelines for the handling, distribution and destruction of narcotics is the Director of Nursing (DON). Guidelines include when a controlled substance arrives from the pharmacy, it should be immediately locked in the narcotic medication drawer, with the INDIVIDUAL Narcotic Sign Out Sheet being placed in a binder. When a narcotic medication is administered it should be signed out in the Individual Narcotic Sign Out record and Medication Administration Record (MAR). If there is a discrepancy in the narcotic count, the DON should be notified immediately. When the medication card is completed, the Individual Sign Out Record should be scanned into the resident chart under the medication section. If a resident is discharged to the hospital, expires, or medication is discontinued, the medications should stay in the medication cart for counting until such time as they can be destroyed. Medication destruction should occur by the DON or designee and a second nurse. The medications destroyed should be recorded on the medication destruction sheet, signed by the two licensed staff doing the destruction and kept in the DON office.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45947</p> <p>Based on interview and record review, the Facility failed to ensure residents receive requested, prescribed pain medications for 2 of 3 residents (R1, R2) reviewed for narcotic use in the sample of 3.</p> <p>Findings include:</p> <p>1. R1's Face Sheet documents R1 was admitted to the facility on [DATE] with diagnoses including cerebral infarction, weakness, pain in left hip, pain in right hip, pain in left knee, and pain in left shoulder.</p> <p>R1's Minimum Data Set (MDS) dated [DATE] documented R1 was cognitively intact and ambulated via wheelchair and walker.</p> <p>R1's Care Plan initiated 7/23/19 documents R1 is at risk for pain related to impaired mobility and diagnoses including cerebral palsy, restless leg syndrome and pain in left shoulder.</p> <p>On 10/22/24 at 9:40 AM, R1 stated the Facility does not order refills on her Tramadol until she runs out completely, so she has to go without it for a period of time before it comes in. She stated, They need to order it before it runs out. Otherwise, I'm in so much pain I can't hardly move. She stated she has gotten into the habit of going to bed early just to avoid it.</p> <p>On 10/23/24 at 9:41 AM, V9, Pharmacy Representative, stated (Pharmacy) received R1's prescription on 8/19/24. She stated it is pretty typical of (Facility) to have a one-to-three-day lag time between the medication running out and obtaining the prescription from the provider.</p> <p>On 10/23/24 at 10:57 AM, R1 stated not having her Tramadol makes it harder for her to sleep at night.</p> <p>R1's Physician Order dated 1/23/24 documents the order 50 mg (milligrams) Tramadol by mouth three times daily for pain.</p> <p>R1's Physician Order dated 3/14/24 documents the order to monitor and record pain every shift.</p> <p>R1's Medication Administration Record (MAR) for the month of August 2024 documents the number 9 next to R2's 8/17/24 and 8/18/24 Tramadol with associated pain levels ranging from zero to four on a scale of ten. The number 9 corresponds to See Nurse's Notes on the chart code.</p> <p>R1's Progress Note dated 8/17/24 documented R2's Tramadol was not in stock. R1's Progress Note dated 8/18/24 documented R2's Tramadol needed a new prescription. R1's Progress Note dated 8/19/24 documented R2's prescription for Tramadol was written.</p> <p>2. R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, chronic obstructive pulmonary disease, low back pain, chronic pain, and fibromyalgia.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's MDS dated [DATE] documented R2 had modified independence with daily decision making skills, required supervision with rolling from side to side, required partial assistance with transfer, and took opioid medications.</p> <p>R2's Care Plan dated 8/27/24 documents R2 has an alteration in pain.</p> <p>R2's Progress Notes document R2 was readmitted to the facility on [DATE] following hospitalization .</p> <p>R2's Physician Order dated 9/14/24 documents the order Oxycodone 10 mg by mouth every four hours as needed for pain.</p> <p>R2's Physician Order dated 9/14/24 documents the order to monitor and document pain level every shift.</p> <p>R2's MAR documents R2 did not receive Oxycodone or have any pain assessments completed from her 9/14/24 readmission until 9/20/24.</p> <p>On 10/22/24, at 1:18 PM, V2, Director of Nursing (DON), stated when a resident is discharged from the hospital and readmitted to our facility, the new prescription orders are put in by the nurse and then signed by the provider and available to the resident. She stated controlled substances have to be faxed and signed which can make the process take longer.</p> <p>On 10/23/24 at 9:20 AM, V8, Registered Nurse (RN), stated R2 did not have any Oxycodone upon her return to the Facility, and they had to order a new prescription, but it may have been pulled from the automated medication dispensing system in the meantime.</p> <p>On 10/23/24 at 9:31 AM, V9, Pharmacy Representative, stated R2's Oxycodone was ordered by the provider on 9/16/24 and delivered to the facility on [DATE].</p> <p>On 10/23/24 at 1:05 PM, V2, Director of Nursing (DON), stated she would expect staff to order medications when they have about two days remaining to ensure they do not run out.</p> <p>On 10/23/24 at 1:40 PM, R2 stated she recently returned from the hospital, and it took days for them to get her Oxycodone, despite staying on their case due to a pain level of more than a ten on a one to ten scale.</p> <p>On 10/24/24 at 8:35 AM, V15, Medical Director, stated he expects medications to be given as prescribed, expects to be notified when residents run out of medications, and expects Facility staff to order medications in such a time frame so the residents do not have to go without the necessary medications.</p> <p>On 10/24/24 at 9:35 AM, V11, [NAME] President (VP) of Clinical Reimbursement, stated the Facility does not have a policy for ordering prescription refills.</p>		