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	03/28/2025

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 - 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** 50908 Based on observation, interview, and record review, the facility failed to prevent physical abuse for 3 of 4 residents (R5, R6, R10) reviewed for Freedom from Abuse and Neglect in a sample of 16. This failure resulted in R6 acquiring a subarachnoid hemorrhage and left orbital wall fracture. Findings include: 1. R6's Face Sheet documented R6 was admitted to the facility on [DATE] with diagnosis of, in part, bipolar disorder, chronic obstructive pulmonary disease and dementia. R6's Minimum Data Set (MDS) dated [DATE] documented she was cognitively intact. R7's Face Sheet documented R7 was admitted to the facility on [DATE] with diagnosis of, in part, schizophrenia, bipolar disorder and dementia. R7's MDS dated [DATE] documented he was cognitively intact. Facility's Serious Injury Incident and Communicable Disease Report dated 3/21/25 documented, It was alleged that there was a resident to resident altercation between (R6) and (R7). Upon investigation, (R7) was in the bathroom when (R6) entered and stood in the doorway as he was using it with her back to him. When he was done, he exited the bathroom pushing her with one hand saying move out my way. (R6) stumbled forward and fell face first to the floor. She was immediately assessed and sent to hospital. I (V1, Administrator) was notified of her being transferred and admitted to another hospital and as a result from this incident she has a fracture of left orbital floor and subarachnoid hemorrhage. The report continued to document, Upon investigation, (R6) was standing in front of the resident restroom door by the nurse's station when a resident was coming out of the restroom. He tried to move her out of the way so he could get by, and she fell face first sustaining a head laceration. She was sent on 3/16/25 to the hospital for evaluation. I (V1) was notified on 3/21/25 when we received and reviewed documentation from the hospital. It was noted she was diagnosed with a subarachnoid hemorrhage with left orbital fracture. Hospital Progress Note dated 3/19/25, documented R6 was diagnosed with SAH (subarachnoid hemorrhage and a L(left) interior orbital wall fracture. (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 - Actual harm Residents Affected - Few	Police report dated 3/18/25, documented On March 18, 2025, the office manager of the facility contacted detective from the number. The manager stated that the incident occurred around approximately 1400 - 1430 hours (2:00 PM-2:30 PM) but it was not captured on video due to the angle of the camera in relation to where the incident occurred. On 3/26/25 at 3:00 PM, R15 stated he saw R7 push R6 down and R6 was lying face down on the floor with blood around her. R15 stated R6 hit her head. R15 stated he did not hear any yelling. R15 stated he thinks R6 made R7 mad by walking in on him while he was using the restroom. On 3/25/25 at 12:35 PM, V1 stated R7 was on the toilet when R6 opened the door on him. R6 yelled and preceded to stand in the doorway with her back toward R7. R7 got up and told R6 to move out of the way while pushing her over. V1 stated he did not witness the incident, but V14 CNA did and R15 did. V1 stated R6 suffered a subarachnoid hemorrhage and was sent to the emergency room immediately. V1 stated he reported the incident. On 3/25/25 at 1:06 PM, V17, R6's daughter/guardian, stated R6's injuries don't seem to match with what the facility says happened. V17 stated R6 suffered life threatening injuries including a brain bleed and broken orbital socket and is still in the hospital now. V17 stated R6 could only remember she was with a staff member then blacked out and was in the ambulance. V17 stated she did talk to the police. On 3/26/25 at 12:30 PM V16, Licensed Practical Nurse, LPN stated R6 gets into a lot of issues and roams a lot, she never liked staying on the female side, would sleep over by the vending machines at the end of the hall down the men's side all the time. V16 stated R6 would get upset easily if someone said or did something she didn't like. V16 stated R6 was just really psychotic, she might be hearing different things not there. V16 stated she's not aware of anything the staff is/was supposed to be doing to try to prevent R6 and R7 from getting into an incident of abuse. On 3/26/25 at 1:15 PM, V15 LPN, stated R6 was noncompliant and very verbally abusive to staff, she was a lady with a lot of behaviors, and it put her in bad situations with other residents. V15 stated R6 was set in her own ways and dismissive to those around her. V15 stated R6 was just a time bomb waiting for something bad to occur, this place was not appropriate for her. V15 stated she's seen R7 hit and punch staff in the past, he doesn't care about others and doesn't understand others enough to prevent an altercation. V15 stated when physical abuse occurs between residents, she separates them first, tends to injuries, notifies the proper people and the administrator. V15 stated 1 on 1 observation interventions seem to really help improve prevention from abuse reoccurring. On 3/26/25 at 1:20 PM V5, Certified Nursing Assistant (CNA) stated R6 was aggressive and confrontational with verbal outbursts, also stubborn with how she wanted things, would curse a lot. V5 stated if R6 could have been strictly separated from the male's side we might not have failed to prevent the incident. On 3/26/25 at 1:43 PM V7, LPN stated V7 stated R6 used to use the restroom on the male's side and her behaviors put her at risk of abuse and she would try to relocate her as much as she could because the men on this side are easily agitated. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 3/26/25 at 4:00 PM, V14 CNA stated she saw the altercation between R6 and R7 take place. V14 stated she heard commotion from R7 yelling which got her attention. V14 stated she saw R6 hit the floor and then R7 came out of the restroom behind her and walked away. V14 stated R6 hit her head, was bleeding and loss consciousness. V14 stated R6 really liked to be over on the male's side but some of the male residents did not like her being over there. V14 stated R7 was probably upset R6 walked in on him using the restroom. 2. R11's face sheet documented R11 was admitted to the facility on [DATE] with diagnosis of, in part, encephalopathy, type two diabetes mellitus, and hemiplegia and hemiparesis. R5's Face Sheet documented R5 was admitted to the facility on [DATE] with diagnosis of, in part, paranoid schizophrenia, mild cognitive impairment and hypertension. The Facility's Serious Injury Incident and Communicable Disease Report dated 3/5/25 documented that R5 was the alleged victim of R11. The report further documented, It was reported that (R11) allegedly stuck (R5) in the dining room. Resident assessment no injuries noted. Local police notified. Investigation initiated. Final to follow. Upon investigation, (R5) took (R11's) food off his plate and ate it. (R11) was upset and made contact with (R5's) chest staff immediately intervened separating both residents removing them from the dining room. (R5) was assessed and no injuries noted. After interviewing him, an order was placed for double portions due to him saying he was still hungry. Staff explained to him that he could have asked for another helping of food. He said he understood. (R11) was educated on informing staff of any issues he may have so that staff can assist him, but it is not ok to put his hands on anyone. Also, both residents had psychosocial follow up interviews, updated care plans and all staff inserviced on abuse and neglect reporting. 3. R10's face sheet documented R10 was admitted to the facility on [DATE] with diagnosis of, in part, unspecified injury of head, traumatic subdural hemorrhage with loss of consciousness, and bipolar disorder. R14's face sheet documented R14 was admitted to the facility on [DATE] with diagnosis of, in part, bipolar disorder, type two diabetes mellitus, and major depressive disorder. The facility's incident report dated 12/19/24, documented, This nurse was alerted by nursing staff that help was needed. On assessment (R10) was in room (XXX) on the floor. Nursing staff stated another resident had pushed (R10) down after he was in their room touching their belongings. (R10) unable to give description. The report continued to document, Nursing staff alerted to (R14's) room. At that time another resident was found on the floor. Nursing staff states (R14) pushed another resident down when the resident entered his room without his knowledge. (R14) states I'm tired of him coming to my room taking my things! You cannot tell me physical abuse and mental abuse are not the same! On 3/27/25 at 1:05 PM, V2, Assistant Director of Nursing, stated all residents have the right to be free of abuse. On 3/27/25 at 9:13 AM, V1, Administrator, stated he agreed that the residents have a right to be free of abuse/neglect/misappropriation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility's Abuse Policy and Prevention Program dated 2022, documented, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, or mistreatment of residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50908 Based on interviews, observations, and record reviews the facility failed to prevent development of additional pressure injuries for 1 of 3 residents, (R1) reviewed for treatment/services to prevent/heal pressure ulcers in a sample of 16. This failure resulted in R1 developing two new Stage 2 pressure injuries. Findings include: R1's Face Sheet, documented R1 was admitted to the facility on [DATE] with diagnosis of, in part, paranoid schizophrenia, pressure ulcer stage 3, and atherosclerotic heart disease. R1's Minimum Data Set (MDS) dated [DATE], documented he is moderately cognitively impaired and required partial/moderate assistance with toileting hygiene; substantial/maximal assistance with showering/bathing and all transfers; and partial/moderate assistance with rolling left to right in bed. R1's Care Plan dated 1/24/25 documented he is at risk for skin complications r/t (related to) psychotropic medications and impaired independence with activities of daily living functions. Stage 3 Pressure ulcer to Coccyx on 6/18/25 interventions to assess and document of progress of areas weekly. On 1/10/25 intervention to assist and encourage resident to turn and reposition every one to two hours and as needed. R1's care plan also documented he has a self-care deficit in bed mobility related to decreased ability to position or reposition self in bed/ turn from side to side; on 11/29/23 a halo bar was placed above the resident's bed for turning and repositioning and to assist with transfers; on 11/29/23 position and reposition resident in bed for comfort, joint support, and skin integrity. On 3/25/25 this surveyor observed R1 to be on his left side at 8:25 AM, 8:35 AM, 8:49 AM, 8:55 AM, 9:10 AM, 9:11 AM, 9:23 AM, 9:35 AM, 9:50 AM, 10:01 AM, 10:16 AM, 10:28 AM. R1's door was left closed from 10:32 AM until 11:22 AM. On 3/25/25 this surveyor observed R1 still on left side at 11:22 AM and 11:33 AM. On 3/24/25 at 9:50 AM, R1 had a sign above his bed stating, turn schedule. On 3/24/25 at 1:50 PM V7, Licensed Practical Nurse (LPN) stated she was not sure how long R1 has had his pressure ulcer but thinks it should be improving with the wound vac, he is typically compliant with that. On 3/24/25 at 2:00 PM, V8, Wound Nurse, stated R1's pressure ulcer was in house acquired and R1 has had it for about 6 months, it started out as moisture associated because he likes to pour liquids on himself leaving him wet. V8 stated the ulcer had slough around it at first and was small but then went to the hospital and came back with it debrided and a lot larger. V8 stated he emphasizes implementing care plans and following interventions to improve patient care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 3/25/25 at 1:17 PM, V8, provided R1 wound care to his stage 4 pressure injury while he was on his left side. After pressure ulcer care was completed, V8 got V11, Certified Nursing Assistant (CNA) to come assist him with peri care on R1. While V11 turned R1 on to his right side, two pressure ulcers with no dressings on them were noticed. V8 stated these were new, facility acquired pressure ulcers. The pressure ulcer to R1's left ischial had approximately 5-6 centimeters of erythema surrounding a darken red wound bed of granulation tissue that was approximately 2 centimeters in diameter with a skin flap peeled open, this part of the wound did not blanch when V8 applied pressure to it. V8 stated he would call this an open blister. R1's new pressure ulcer to his left hip had erythema covering approximately 4 centimeters in width by 1.5 centimeters in length with a patch of open excoriated skin in the center approximately 0.5 centimeter in diameter. V8 stated that the hip pressure ulcer was from R1's catheter tubing being underneath him while on his left side, it has the exact indentation of it. V8 stated it could have been caused by excessive time being on top of the tubing without being repositioned. V8 preceded to take pictures of both the wounds, applied skin prep to them and a bordered foam dressing to the left ischial and an island dressing to the left hip. V8 stated he would notify the wound nurse practitioner and get new orders for care. At 2:23 PM, V11 and V8 turned R1 back on to his left side. V11 and V8 stated they turned R1 on his left side again because he won't stay on his right side. V11 and V8 stated we can turn R1 on his right side and show that he won't stay there. R1 was turned to his right side by V11 and V8 cooperatively without complaints or refusal. R1's Skin and Wound assessment dated [DATE] documented an in-house acquired blister to his left ischial tuberosity involving 100% granulation to the wound bed and to have erythema surrounding it. On 3/25/25, a second Skin and Wound Assessment documented a new in-house acquired skin tear to R1's rear left trochanter (hip) with 100% granulation to the wound bed and erythema surrounding. On 3/26/25 at 8:41, AM, R1 stated he doesn't mind being turned and doesn't refuse unless the staff reposition him roughly because his butt hurts. R1 stated the staff will sometimes drag my butt when they turn me and it hurts a lot but if they are gentle, I don't care what side I'm on. R1 stated no one asked or offered to turn me yesterday. R1 stated he was on his left side for most of the day 3/25/25. On 3/26/25 at 3:53 PM, R16, R1's roommate, stated he doesn't see staff come in and turn him frequently. On 3/26/25 at 12:30 PM, V16, LPN, stated residents are on turn schedules to prevent break down of the skin, if a resident is non-compliant V16 stated she would try to at least offer a wedge under one side to turn even slightly. On 3/26/25 at 1:20 PM, V5 CNA stated turning schedules prevent skin break down and wounds from worsening, typically occurring every 1-2 hours. V5 stated if a resident is noncompliant with turning, a wedge can be used to turn them slightly and offer encouragement. V5 stated if a resident is not turned it is likely to cause a sore. On 3/27/25 at 1:05 PM, V2, Assistant Director of Nursing, stated she expects the nursing staff to be turning residents that require it at least every two hours, if they do not turn a resident within that timeframe, they are at risk for causing skin break down. V2 stated she does not expect a resident to be lying on top of a catheter tube, this could cause skin sores. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility's Turning and Reposition Policy dated 8/2024 documented all residents at risk of, or with existing pressure injuries, will be turned and repositions, unless it is contraindicated due to a medical condition. In this case, small shifts in repositions with be employed. Repositioning techniques in bed includes avoiding positioning the resident onto medical devices or other foreign objects and avoid positioning residents on surfaces with existing pressure injuries, including persistent redness. Repositioning techniques in chair include if the resident is unable to make position changes, reposition every hour. The facility's Skin Management: Pressure Injury Treatment/General Wound Treatment Policy dated 10/2024 documented for management of tissue loads, pressure redistribution devices offer an effective means of reducing interface pressure but because they cannot provide pressures consistently less than 25 to 32 mm/HG (millimeters of mercury), a turning schedule should be implemented as well.