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	04/29/2025

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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on observation, interview, and record review, the facility failed to provide timely incontinent/colostomy care in 1 of 1 resident (R2) reviewed for ADL (Activities of Daily Living) care in the sample of 6. This failure resulted in R2 developing painful, red excoriation around his colostomy site extending down to the abdomen, perineal area and buttocks. Findings include: On 4/23/25 at 8:45 AM, R2 was observed in bed with V8, R2's family member at bedside. R2's colostomy site and abdomen were observed with V8. There was a towel covering R2's abdomen, V8 removed the towel and R2's colostomy bag was about 3/4 full and was leaking moderate amounts of liquid stool onto R2's abdomen, down into R2's abdominal folds, perineal area and under R2's bottom. R2's abdomen was red and excoriated. R2 was stating don't touch it, it hurts, burns and was shaking, appearing to be apprehensive and in pain. On 4/23/25 at 8:55 AM, R2 turned his call light on, V9, CNA (Certified Nurse's Assistant) came into the room, asked what was needed and then left the room to gather supplies. Upon V9's return, V9 explained to R2 that she was going to clean him up, R2 was shaking his head no and stating it hurts, it burns, don't use the cleaner in the white bottle pointing to a bottle of wound cleanser. V9 was able to calm R2 and R2 agreed to allow V9 to clean him up. V9 attempted to clean R2, but liquid feces continued to leak from the bottom of the colostomy wafer that attaches to the bag. During this time R2 continued to shake and appeared to be in pain. V9 stated the nurse would need to change the colostomy bag because it kept leaking. V9 then left the room and notified V10, RN (Registered Nurse). On 4/23/25 at 9:20 AM, V10, RN, came into R2's room to change R2's colostomy wafer and bag. The wafer and bag was removed with red excoriation noted around the colostomy site extending down to R2's abdomen, abdominal folds and perineal area. V10 cleaned around R2's colostomy site and abdomen with incontinence wipes, then applied a new wafer and bag. V10 told R2 and V8 that she would need to get a CNA to finish cleaning R2 up because she still had a lot of medications to give. The liquid feces remained on R2's lower pubic area, buttocks on the incontinence pad underneath R2. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Belleville Healthcare Center	727 North 17th Street Belleville, IL 62226

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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 0677 Level of Harm - Actual harm Residents Affected - Few	On 4/23/25 at 10:30 AM, R2 was observed still soiled with liquid feces on his lower pubic area, buttocks and incontinence pad. An aide from Hospice, came in R2's room to see him, V8 told her that he had been waiting over an hour to get cleaned up. The aide then cleaned R2 up. R2's perineal area and buttocks were red. V8 was in R2's room and stated she has been at R2's bedside and no one from the facility came in to change R2, so the hospice aide did it, the facility CNAs never came to R2's room after V10 left the room. On 4/26/2025 at 9:42 PM, V18, family member, came to the nurse's station and put a container on the counter and stated, R2 just threw up and nobody has been checking on him. I told you two hours ago he said he was not feeling well. His call light in his room does not work and if I had not been here, he would have thrown up all over himself because nobody is checking on him. This is not right. On 4/26/2025 at 9:46 PM, R2's call light was tested and did not work. On 4/26/2025 at 9:52 PM, V18, R2's family member, stated I told them at 8:00 PM, that he was not feeling well, and nobody has been down here to check on him. He is like a kid; his call light does not work. I told them he needed checked on, but they don't care. What would have happened if I was not here? On 4/26/2025 at 9:58 PM, V23, CNA stated I am not sure what is happening with (R2). R2's Face Sheet, undated, documents R2 has the following diagnoses: Unspecified Kidney Injury, Pituitary Dependent Cushing's Disease, Hypertension, Autism, Congenital Renal Failure, Acquired Absence of Parts of the Digestive Tract, Presence of Functional Implants, Acute Infarction of the Large Intestine, Chronic Kidney Disease and Critical Illness Polyneuropathy. R2's (MDS) Minimum Data Set, dated dated [DATE], documents R2 has a BIMS (Brief Interview of Mental Status) score of 8, indicating R2 has moderate cognitive impairment, is dependent with toileting and has no skin issues. R2's Care Plan, dated 4/21/25, documents R2 requires assist with daily care needs, is incontinent of bowel and bladder, has a potential risk for complications related to altered elimination for bowel elimination, as evidenced by a colostomy and is at risk for skin complications related to Stoma Incontinence Associated Dermatitis with an intervention to provide skin care after each incontinence episode. R2's Wound Care Note, dated 4/8/25, documents R2 has incontinence associated dermatitis. Treatment: cleanse wound with soap and water, pat dry and apply triad and miconazole cream BID (Twice Daily) and PRN (As Needed). Leave open to air. R2's Grievance, dated 4/16/25, filed by V8, documents R2 was put in diapers and not attended to throughout the night. Findings: CNA educated on the needs of the resident and customer service. (continued on next page)

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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 0677 Level of Harm - Actual harm Residents Affected - Few	On 4/23/25 at 8:45 AM, V8, R2's family member, stated R2 is Autistic and doesn't always know or understand what is going on. V8 stated about a year ago, he had his gallbladder removed at a local hospital, he developed an infection in his blood and surgical wound resulting in the colostomy. V8 stated R2 was transferred to a higher acuity hospital, then to 2 different rehab hospitals and before coming to this facility. V8 stated R2 has been at the facility for a short time and the staff isn't changing his colostomy bag, so feces is coming out and sitting on his skin for long periods of time resulting in a painful red rash all over his belly. V8 stated when R2's bag is full, that is when it leaks onto his belly and into his folds. On 4/23/25 at 11:00 AM, V1, Administrator, stated he spoke with V8, R2's family member, regarding her concerns with R2's care. V1 stated they had placed a diaper on R2, so he put a sign on R2's wall, not to use diapers and educated the staff. V1 stated he isn't familiar with colostomies, so he spoke with V5, Wound Nurse, who explained to him that when the feces sits on the skin it can make it excoriated and he recommended to place a towel under and below the colostomy in case it starts leaking. V1 has instructed the nursing staff to make sure it is checked frequently, and care provided as needed. V1 stated the problem occurred (referring to the grievance) during the night with an agency nurse that wasn't familiar with R2's care or how he is because they don't have any other residents like him, so that agency nurse was also educated. V1 stated he checks on R2 and speaks with V8 everyday to make sure R2 is being cared for. On 4/24/25 at 10:50 AM, V5, Wound Nurse, stated feces shouldn't be left on the skin because it causes excoriation. V5 stated he would expect the nursing staff to keep R2 clean, change his bag and apply the creams as ordered. The Incontinence Care Policy, dated 1/2025, documents incontinence care is provided to keep residents as dry, comfortable and odor free as possible. It also helps in preventing skin breakdown.

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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 0691 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on observation, interview, and record review, the facility failed to provide colostomy care to 1 of 1 resident (R2) reviewed for ostomy care in the sample of 6. This failure resulted in R2 developing painful, red excoriation around the colostomy site extending down to the abdomen and perineal area. Findings include: On 4/23/25 at 8:45 AM, R2 was observed in bed with V8, R2's family member at bedside. R2's colostomy site and abdomen were observed with V8. There was a towel covering R2's abdomen, no abdominal binder present, V8 removed the towel and R2's colostomy bag was about 3/4 full and was leaking moderate amounts of liquid stool onto R2's abdomen, down into R2's abdominal folds, perineal area and under R2's bottom. R2's abdomen was red and excoriated. R2 was stating don't touch it, it hurts, burns and was shaking, appearing to be apprehensive and in pain. On 4/23/25 at 8:55 AM, R2 turned his call light on, V9, CNA (Certified Nurse's Assistant) came into the room, asked what was needed and then left the room to gather supplies. Upon V9's return, V9 explained to R2 that she was going to clean him up, R2 was shaking his head no and stating it hurts, it burns, don't use the cleaner in the white bottle pointing to a bottle of wound cleanser. V9 was able to calm R2 and R2 agreed to allow V9 to clean him up. V9 attempted to clean R2, but liquid feces continued to leak from the bottom of the colostomy wafer that attaches to the bag. During this time R2 continued to shake and appeared to be in pain. V9 stated the nurse would need to change the colostomy bag because it kept leaking. V9 then left the room and notified V10, RN (Registered Nurse). On 4/23/25 at 9:20 AM, V10, RN, came into R2's room to change R2's colostomy wafer and bag. The wafer and bag was removed with red excoriation noted around the colostomy site extending down to R2's abdomen, abdominal folds and perineal area. V10 cleaned around R2's colostomy site and abdomen with incontinence wipes, then applied a new wafer and bag. V10 told R2 and V8 that she would need to get a CNA to finish cleaning R2 up because she still had a lot of medications to give. The liquid feces remained on R2's lower pubic area, buttocks on on the incontinence pad underneath R2. On 4/23/25 at 10:30 AM, R2 was observed still soiled with liquid feces on his lower pubic area, buttocks and incontinence pad. An aide from Hospice, came in R2's room to see him, V8 told her that he had been waiting over an hour to get cleaned up. The aide then cleaned R2 up. R2's perineal area and buttocks were red. V8 was in R2's room and stated she has been at R2's bedside and no one from the facility came in to change R2, so the hospice aide did it, the facility CNAs never came to R2's room after V10 left the room. On 4/23/25 and 4/24/25, R2 was observed without the abdominal binder in place. R2's Face Sheet, undated, documents R2 has the following diagnoses: Unspecified Kidney Injury, Pituitary Dependent Cushing's Disease, Hypertension, Autism, Congenital Renal Failure, Acquired Absence of Parts of the Digestive Tract, Presence of Functional Implants, Acute Infarction of the Large Intestine, Chronic Kidney Disease and Critical Illness Polyneuropathy. (continued on next page)

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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 0691 Level of Harm - Actual harm Residents Affected - Few	R2's (MDS) Minimum Data Set, dated dated [DATE], documents R2 has a BIMS (Brief Interview of Mental Status) score of 8, indicating R2 has moderate cognitive impairment, is dependent with toileting and has no skin issues. R2's Care Plan, dated 4/21/25, documents R2 requires assist with daily care needs, is incontinent of bowel and bladder, has a potential risk for complications related to altered elimination for bowel elimination, as evidenced by a colostomy and is at risk for skin complications related to Stoma Incontinence Associated Dermatitis with an intervention to provide skin care after each incontinence episode. R2's Progress Note, dated 3/25/25 at 11:44 AM, documents the following: Patient arrived at nursing facility via EMS (Emergency Medical Services. Patient transferred from gurney into bed. Patient oriented to room and call light system. Patient was able to give return demonstration on using the call light. Patient alert and oriented times 3. The patient reports feeling nervous and afraid. Patient reassured that he was safe, and the nursing staff will attend to his needs. Patient mother at bed side. The patient denied pain at time of assessment. Patient respiration even and not-labored. Patient lungs clear throughout. Patient noted to have a g-tube (gastrostomy tube) at left mid abdomen- patent and intact, colostomy at right mid abdomen- no stoma noted. Patient has an opening to the right mid abdomen, but stoma is submerged in abdominal cavity. Abdominal area surrounding opening red and excoriated. Patient abdomen soft and non-distended. Patient bowel sound present. The patient is noted to have redness to pannus and groin and perineal area. Patient to bed sent to ER (emergency room) for evaluation for stoma evaluation. R2's Progress Note, dated 3/25/25 at 5:32 PM, documents the following: Patient back from hospital at 1733 (5:33 PM) via 2 EMT (Emergency Medical Technician). Resident's stoma looks normal. Resident is resting in bed with his family around. No c/o (complaints) pain and distress. Will continue to monitor. R2's Progress Note, dated 4/8/25 at 9:21 PM, documents the following: Patient continues on hospice care, g-tube patent/intact, remains afebrile. Colostomy intact, patient keeps messing with it, so it keeps leaking. Skin on abdomen has redness. Patient cleaned as needed. Plan of care ongoing. R2's Progress Note, dated 4/9/25 at 10:39 AM, This Care Plan nurse met with resident and residents' mother regarding resident pulling and tampering with colostomy device after being placed on resident. Residents mother expressed that resident has no understanding due to his diagnosis of why he shouldn't mess with the colostomy device and the risk of further damaging the skin integrity by doing so. Resident was encouraged to notify staff if his colostomy was bothering him which he agreed. Resident colostomy bag is currently in place and intake. Staff will be encouraged to check resident for any signs of colostomy bag being compromised. R2's Wound Care Note, dated 4/8/25, documents R2 has incontinence associated dermatitis. Treatment: cleanse wound with soap and water, pat dry and apply triad and miconazole cream BID (twice daily) and PRN (as needed). Leave open to air. R2's Wound Care Note, dated 4/15/25, documents R2's incontinence associated dermatitis is resolved and triad and miconazole cream was changed to PRN. (continued on next page)

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F 0691 Level of Harm - Actual harm Residents Affected - Few	R2's (POS) Physician Order Sheets were reviewed with the following orders noted: 3/28/25, Comfort focused treatment; 3/28/25 - Abdominal Binder/Elastic Large Miscellaneous (Elastic Bandages & Supports). Apply to Abdomen topically one time a day for skin redness; Excoriation; 4/15/25 - Triad Hydrophilic Wound Dress External Paste. Apply to Abdomen and Groin topically as needed for skin redness; 4/15/25 - Micatin Cream 2 % (Miconazole Nitrate). Apply to Abdomen and Groin topically as needed for skin redness. There were no orders for colostomy care or how often to change the colostomy bag on the POS. R2's (TAR) Treatment Administration Record, documents the following: Micatin (Miconazole) and Triad cream was not applied as ordered on 4/8/25, 4/9, 4/12/25, or 4/15/25. The new orders on 4/15/25, changing them to PRN has not been applied since the new order was received. There was no documentation of colostomy care or when the colostomy bag was changed on the TAR. R2's Grievance, dated 4/16/25, filed by V8, documents R2 was put in diapers and not attended to throughout the night. Findings: CNA educated on the needs of the resident and customer service. On 4/23/25 at 8:45 AM, V8, R2's, family member, stated R2 is Autistic and doesn't always know or understand what is going on. V8 stated about a year ago, he had his gallbladder removed at a local hospital, he developed an infection in his blood and surgical wound resulting in the colostomy and he has a feeding tube that they use for his medications because he won't take them by mouth. V8 stated R2 was transferred to a higher acuity hospital, then to 2 different rehab hospitals and then to this facility. V8 stated he has been at the facility for a short time and the staff isn't changing his colostomy bag, so feces is coming out and sitting on his skin for long periods of time resulting in a painful red rash all over his belly. V8 stated when R2's bag get's full, that is when it leaks onto his belly and into his folds. V8 stated some of the nurses told her that he messes with it, but that isn't true, he doesn't like it to be changed because it hurts, but he does allow them to do it, he just moves around. V8 stated sometimes he'll remove the towel to look and see what it looks like when it's leaking and then covers it back up. V8 stated the problem was mainly on the night shift. V8 stated R2 is on hospice because his kidneys are failing, and they decided not to put him on hemodialysis. V8 stated hospice provides all of R2's colostomy, incontinent supplies and medications/creams/powders. On 4/24/25 at 8:30 AM, V8, family member at bedside and stated no one has come into R2's room to check on him this morning. On 4/23/25 at 9:20 AM, V10, RN, stated the nurses change the colostomy bags as needed. V10 stated, R2 is picky with his changes, because he knows what makes him hurt and what doesn't, so he only likes certain products used. V10 stated hospice provides R2's colostomy supplies, wound care medications/powders/creams, incontinent wipes and incontinent pads. On 4/23/25 at 9:30 AM, V4, MDS/Care Plan Coordinator, stated R2 picks at the colostomy bag so it becomes loose and leaks. (continued on next page)

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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 0691 Level of Harm - Actual harm Residents Affected - Few	On 4/23/25 at 11:00 AM, V1, Administrator, stated he spoke with V8, regarding her concerns with R2's care. V1 stated they had placed a diaper on R2, so he put a sign on R2's wall, not to use diapers and educated the staff. V1 stated he isn't familiar with colostomies, so he spoke with V5, Wound Nurse, who explained to him that when the feces sits on the skin it can make it excoriated and he recommended to place a towel under and below the colostomy in case it starts leaking. V1 has instructed the nursing staff to make sure it is checked frequently, and care provided as needed. V1 stated the problem occurred (referring to the grievance) during the night with an agency nurse that wasn't familiar with R2's care or how he is because they don't have any other residents like him, so that agency nurse was also educated. V1 stated he checks on R2 and speaks with V8 everyday to make sure R2 is being cared for. On 4/24/25 at 10:50 AM, V5, Wound Nurse, stated they are using Miconazole and Triad creams for R2's excoriation to his abdomen. V5 stated it helps with the excoriation and the burning sensation/pain caused by the excoriation. V5 stated the excoriation is chronic, comes and goes. V5 stated R2's reaction to the excoriation is 50/50 pain and anxiety, R2 has Autism, so it causes him anxiety and he guards that area. V5 stated R2 does pick/mess with the bag, and it leaks constantly. V5 stated feces shouldn't be left on the skin because it causes excoriation. V5 stated he would expect the nursing staff to keep R2 clean, change his bag and apply the creams as ordered. The Colostomy/Ileostomy Care Policy, dated 6/2015, documents the purpose is to provide guidelines that will promote cleanliness, protect peritoneal skin from irritation and infection and exposure to fecal matter. Colostomy/Ileostomy bags will be changed at a minimum once every 5 days and as needed. Apply barrier cream as indicated, document in the nursing notes any skin issues and the condition of the stoma, report these issues to the physician, and document the changing of the colostomy bag on the TAR.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42636 Based on observation, interview, and record review, the facility failed to identify pain and provide pain relief to 1 of 1 resident (R2) reviewed for pain management in the sample of 6. This failure resulted in R2 having pain and discomfort related to excoriation around his colostomy site extending down to the abdomen and perineal area and that is not being treated or recognized. Findings include: On 4/23/25 at 8:45 AM, R2 was observed in bed with V8, family member, at bedside. R2's colostomy site and abdomen were observed with V8. There was a towel covering R2's abdomen, no abdominal binder present, V8 removed the towel and R2's colostomy bag was about 3/4 full and was leaking moderate amounts of liquid stool onto R2's abdomen, down into R2's abdominal folds, perineal area and under R2's bottom. R2's abdomen was red and excoriated. R2 was stating don't touch it, it hurts, burns and was shaking, appearing to be apprehensive and in pain. On 4/23/25 at 8:55 AM, R2 turned his call light on, V9, CNA (Certified Nurse's Assistant) came into the room, asked what was needed and then left the room to gather supplies. Upon V9's return, V9 explained to R2 that she was going to clean him up, R2 was shaking his head no and stating it hurts, it burns, don't use the cleaner in the white bottle pointing to a bottle of wound cleanser. V9 was able to calm R2 and R2 agreed to allow V9 to clean him up. V9 attempted to clean R2, but liquid feces continued to leak from the bottom of the colostomy wafer that attaches to the bag. During this time R2 continued to shake and appeared to be in pain. On 4/23/25 at 9:20 AM, V10, RN, came into R2's room to change the colostomy bag. The bag was removed and there was red excoriation noted around the colostomy site extending down to R2's pubic area. V10 cleaned around the colostomy site, R2's abdomen and pubic area with incontinent wipes, this is what R2 prefers to be used. V10 then placed a new colostomy bag and told R2 and V8 that she would need to get the CNA to finish cleaning him up because she still had a lot of medications to give. No creams were applied, and the feces remained on R2's lower pubic area, buttocks and on the disposable incontinence pad under R2. On 4/23/25 at 10:30 AM, R2 was still soiled and hadn't been cleaned up, hospice aid arrived and cleaned R2 up. R2's perineal area and buttocks were red. V8, R2's Mom, in room and stated she has been at R2's bedside and no one from the facility has changed R2 until now, the CNA never came back to the room after V10 left. R2's Face Sheet, undated, documents R2 has the following diagnoses: Unspecified Kidney Injury, Pituitary Dependent Cushing's Disease, Hypertension, Autism, Congenital Renal Failure, Acquired Absence of Parts of the Digestive Tract, Presence of Functional Implants, Acute Infarction of the Large Intestine, Chronic Kidney Disease and Critical Illness Polyneuropathy. R2's (MDS) Minimum Data Set, dated dated [DATE], documents R2 has a BIMS (Brief Interview of Mental Status) score of 8, indicating R2 has moderate cognitive impairment. (continued on next page)

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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 0697 Level of Harm - Actual harm Residents Affected - Few	R2's Care Plan, dated 4/21/25, documents R2 has an alteration in comfort due to advanced disease process with the following interventions: assess effectiveness of pain medication, assess pain characteristics: duration, location, quality, encourage to report any pain, and to report any acute changes to Physician. There are not any interventions for R2's pain from the excoriation or how to effectively assess and act on R2's pain in relationship to his diagnosis of Autism and cognitive disabilities. R2's Progress Note, dated 4/8/25 at 9:21 PM, documents the following: Patient continues on hospice care, g-tube patent/intact, remains afebrile. Colostomy intact, patient keeps messing with it, so it keeps leaking. Skin on abdomen has redness. Patient cleaned as needed. Plan of care ongoing. There was no documentation in R2's records of him being assessed for pain since 3/30/25. R2's Wound Care Note, dated 4/8/25, documents R2 has incontinence associated dermatitis. Treatment: cleanse wound with soap and water, pat dry and apply triad and miconazole cream BID (twice daily) and PRN (as needed). Leave open to air. R2's Wound Care Note, dated 4/15/25, documents R2's incontinence associated dermatitis is resolved and triad and miconazole cream was changed to PRN. R2's (POS) Physician Order Sheets were reviewed with the following orders noted: 3/28/25, Comfort focused treatment; 4/15/25 - Triad Hydrophilic Wound Dress External Paste. Apply to Abdomen and Groin topically as needed for skin redness; 4/15/25 - Micatin Cream 2 % (Miconazole Nitrate). Apply to Abdomen and Groin topically as needed for skin redness. R2's (TAR) Treatment Administration Record, documents the following: Micatin (Miconazole) and Triad cream has not been applied since 4/14/25. R2's Pain Assessment, dated 3/25/25, documents the following: pain scale for cognitively impaired: displays vocal c/o (complaints) pain, facial grimacing, bracing and restlessness, characteristics - aching, burning, Faces scale - hurts a little bit. On 4/23/25 at 8:45 AM, V8, family member, stated R2 is Autistic and doesn't always know or understand what is going on. V8 stated about a year ago, he had his gallbladder removed at a local hospital, he developed an infection in his blood and surgical wound resulting in the colostomy. V8 stated R2 was transferred to a higher acuity hospital, then to 2 different rehab hospitals and then to this facility. V8 stated he has been at the facility for a short time and the staff isn't changing his colostomy bag, so feces is coming out and sitting on his skin for long periods of time resulting in a horrible painful red rash all over his belly. V8 stated when R2's bag is full, that is when it leaks onto his belly and into his folds. V8 stated some of the nurses told her that he messes with it, but that isn't true, he doesn't like it to be changed because it hurts, but he does allow them to do it, he just moves around. On 4/24/25 at 8:30 AM, V8, R2's Mom at bedside and stated no one has come into R2's room to check on him this morning. (continued on next page)

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	04/29/2025

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

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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 0697 Level of Harm - Actual harm Residents Affected - Few	On 4/24/25 at 10:50 AM, V5, Wound Nurse, stated they are using Miconazole and Triad creams for R2's excoriation to his abdomen. V5 stated it helps with the excoriation and the burning sensation/pain caused by the excoriation. V5 stated the excoriation is chronic, comes and goes. V5 stated R2's reaction to the excoriation is 50/50 pain and anxiety, R2 has Autism, so it causes him anxiety and he guards that area. V5 stated feces shouldn't be left on the skin because it causes excoriation and pain. V5 stated he would expect the nursing staff to keep R2 clean, change his bag and apply the creams as ordered. The Pain Management Policy, dated 1/20/20, documents the following: The purpose is to facilitate resident independence, promote resident comfort and preserve resident dignity. This will be accomplished through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. The pain management is based on a facility-wide commitment to resident comfort. Pain is defined as whatever the experiencing person says it is and exists whenever he or she says it does. Pain Management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical need. Pain management is a multidisciplinary care process that includes the following: effectively recognizing the presence of pain, identifying the characteristics of pain, addressing the underlying causes of the resident's pain, identifying and using specific strategies for different levels and sources of pain, monitoring for the effectiveness of interventions and modifying approaches as necessary. Pain will be assessed at least once every shift and documented in the EMAR (Electronic Medication Record) using the pain scale appropriate for the patient. Based on the documentation, a pain management care plan will be developed, maintained, and/or updated. If nursing staff recognizes pain, the staff may attempt non-pharmacological interventions, physical modalities, body alignment, rehabilitation therapy, exercises, and/or cognitive behavioral interventions.