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	03/14/2025

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45302 Based on interview and record review, the facility failed to send a medical record request in a timely manner for 1 (R174) of 3 residents reviewed for medical records in the sample of 39. R174's Undated Face Sheet documents she was initially admitted to the facility on [DATE]. R174's Nurse Progress Note, dated 8/13/2024 at 11:52 PM documents upon during rounds this nurse noted labored breathing. Vital signs 104/69, heartrate 60, oxygen saturation 77%, respirations 18, temperature 97.6 degrees. Secretions noted to the back of throat. PRN (when needed) nebulizer given as ordered. Suction administered to clear airway. Oxygen saturation now at 80%. Nurse practitioner called and gave orders to send to ED (emergency department) to eval (evaluate) and TX (treatment). POA (Power of Attorney) called and VM (voicemail) left. DON (Director of Nurses) called and VM left. On 3/12/2025 at 2:00 PM V8, Medical Records stated another IDPH (Illinois Department of Public Health) surveyor came out to the facility and investigated the allegation of R174's family not receiving medical records. She didn't receive any communication that R174's family wanted medical records until she received a follow up subpoena letter at the end of February 2025. V1, Administrator told her to send the medical records request to the medical record processing center the same day. She faxed the request on 2/26/2025. That was the first and only time she was told to share medical records with R174's family. V8 stated when a resident is discharged from the facility or passes away if the family wants medical records, they generally call her and she requests an email address from them and she sends the medical request form to them via email. No one contacted her regarding R174's medical record, she didn't have an email to send the medical request form to and no one has requested R174's medical records that she is aware of prior to 2/26/2025. Other resident family members that requested medical records after their family was discharged from the facility were R176's daughter. She came up to the facility and completed the medical record request form and it was emailed to the medical request processing center the same day on 2/26/2025. R79's family completed the medical record request form, and it was emailed to the medical record request processing center on 2/24/2025. Review of R174's subpoena and notice of deposition regarding medical and billing records dated 12/18/2025 via certified mail to the facility's corporate office. Review of R174's follow up on the subpoena letter dated 2/21/2025 for medical records and billing was mailed regular United States mail directly to the facility. (continued on next page)

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

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/12/2025 at 2:40 PM V1, Administrator stated he started working as the Administrator at the facility on 2/3/2025 and he received R174's medical records request in the mail on 2/26/2025 and he forwarded the request to V8 and to V9, facility's attorney and the medical record request was forwarded to the medical records processing center. On 3/12/2025 at 2:55 PM V6 stated she started working as the regional nurse consultant in September 2024 and she has not received a medical records request for R174. The subpoena was sent to corporate office and addressed to V9 so he would have been the one to send the medical record request to the medical records processing center. V6 stated she doesn't know why R174's medical records were not sent after V9 received the subpoena. On 3/13/2025 at 10:40 AM V9, facility attorney stated he doesn't recall receiving a subpoena after December 18, 2024, regarding R174's medical and billing documents to be sent. If he did receive the certified letter, he would have notified the medical records processing center to send the medical documents, but he didn't know if he received the certified letter or not at this time. At 11:59 PM V9 stated he didn't have documentation that he received a certified letter in the mail regarding R174's medical and billing records in December 2024 if he would have received it, he would have immediately emailed the medical records processing center and he checked documentation and didn't have one sent for R174. On 3/13/2025 at 11:27 AM the Records Processing Center replied to an email and documented a request was received from the facility on behalf of the law office in late February 2025. An invoice was sent to the law office. Our audit report indicates that although the invoices has been viewed by the law office twice, it remains outstanding and not paid. On 3/13/2025 at 2:00 PM V10, Attorney for R174 stated her law office sent a certified letter to the facility corporate office addressed to R9 on 12/18/2024 and she sent a check to pay for mileage and appearance check #2917 for the amount of $155.34 for the deposition to be held on 1/17/2025. V10 stated the facility agent (R9) didn't appear at the deposition on 1/17/2025. She sent a regular letter to the facility on [DATE] and has not received any medical or billing records from the facility as of 3/13/2025. V10 stated she hasn't received an invoice from the medical record processing center or notice from anyone from the facility to pay for the medical and bill record documents. V10 stated she'd be happy to pay the fees she just needs an invoice. Review of the certified letter dated 12/18/2024 documents a confirmation receipt. The certified letter was received at the facility and left with a person on 12/21/2024. Review of the check #2917 delivered to the facility's corporate office in the certified letter dated 12/18/2024 was cashed on 12/27/2024. (continued on next page)

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Medical Records Request Policy reviewed date 9/2024 documents all requests for medical records will be given to the Administrator. If the request is determined to be in anticipation of litigation, the RNC (regional nurse consultant) will complete a review of the medical record. Once a medical record review is complete and the requesting party has been determined to have authority to obtain a copy, the facility will notify the requesting party of the cost of copies. All parties requesting copies of medical records will be charged for copies in accordance with State regulations. The Administrator may after consultation with the RNC waive the copying cost in order to reduce the likelihood of litigation. Medical records should be sent offsite to be scanned in order to reduce copying costs.

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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** 43794 Based on interview and record review the facility failed to prevent abuse for 3 of 7 (R20, R30, R62) residents investigated for resident-to-resident abuse in a sample of 39. Findings include: 1. R20's EMR (Electronic Medical Records) undated documents that the resident was admitted to the facility on [DATE]. R20's EMR dated 07/28/16 documents a diagnosis of Schizophrenia. R20's MDS (Minimum Data Set) dated 02/04/25 documents a BIMS (Brief Interview for Mental Status) score of 6 out of 15. The MDS documents that the resident has not exhibited physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, or other behavioral symptoms not directed towards others. R20's Care Plan dated 9/27/23 documents (R20) has a history of aggressive, inappropriate, attentions-seeking and/or maladaptive behavior. The resident has a diagnosis of paranoid schizophrenia. 06/14/22 (R20) was verbally and physically aggressive towards a peer. 02/19/23 Got mad and was verbally aggressive towards staff in the dining room and threw his drink on staff. 3/15/23 verbally aggressive with staff in dining room. 7/18/23 (R20) was noted being physically aggressive with staff. 9/9/2023 (R20) became physically aggressive towards another resident. 09/26/2023 - physically aggressive. R20's Nurses Notes dated 05/01/24 at 9:40 PM documents Per stated res was in dinning threw and hit resident (R31) with a chair, unknown why, called police report # 2024-025107, V18, NP (Nurse Practitioner), (V19) POA (Power of Attorney) aware at this time. Facility's Abuse Report dated 05/01/24 documents Resident (R20) tossed chair in dining room in the direction of resident (R31). She was assessed for injury and notifications made to respective RP's and doctors. Resident separated and ADM notified. Investigation started. Final report to follow. Based on resident and staff interviews and statements from residents involved, the allegation was substantiated. The perpetrator admitted that he threw the chair but gave no reason for the action. However, due to his diagnosis and the circumstance surrounding the incident, he gave no indication that he intended to harm the victim. It is possible that he tossed the chair in her direction because the other resident was merely in the dining room. R20's Nurses Note dated 12/22/24 at 3:50 PM documents The resident hit another resident with the caution floor sign. I redirected the resident to his room. I notified the on-call nurse at 1555 pm and she returned my call at 1611 pm. I notified the resident's POA (V19) at 1615 pm. Facility's abuse investigation dated 12/22/24 documents Res to Res incident. (R59) walked into (R20's) room to talk to his roommate and (R20) got upset. (R20) hit (R59) with the floor sign. Nurse assessed (R59) and he denied pain. No bruising or injury noted. QA (Quality Assurance) team met and will discuss with (R59) to not enter that room and to ask the roommate to go to his room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R30's EMR undated documents that the resident was admitted to the facility on [DATE]. R30's EMR dated 4/12/19 documents a diagnosis of Schizophrenia, unspecified. R30's MDS dated [DATE] documents that a BIMS score could not be completed because resident is rarely/never understood. The MDS documents that the resident has not exhibited physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, or other behavioral symptoms not directed towards others. R30's Care Plan dated 5/10/24 documents (R30) is at risk for abuse and/or neglect related to Dx: Schizophrenia, psychotropic medications, diagnosis of dementia, confusion/disorientation/forgetfulness, poor judgement skills, difficulty in communication, history of verbal and physical aggression and poor personal hygiene. (R30) will mumble at times while walking around the facility. (R30) will curse at staff and peers. 9/29/23 resident was reported to have had an incident with peer. 10/5/23 chair was pushed into this resident's arm by peer. 5/1/24 resident physically aggressive with peer. There is no progress note for this incident. Facility's Abuse Investigation dated 12/14/24 documents (R30) went to grab (R31) cup of water and (R31) started to yell at her. (R30) punched (R31) in the face. No injuries noted. (R31) denied any pain. No swelling noted. Resident immediately separated by staff. 3. Facility's Abuse Investigation dated 07/05/24 documents (R92) a 60 y/o male whom is A/O to self with the following DX: other schizophrenia, diffuse traumatic brain injury without loss of consciousness, subsequent encounter. (R62) a 48 y/o female whom is A/O to person, place and situation with the following DX: Major depressive disorder, undifferentiated schizophrenia. (R92) made contact with (R62) to obtain attention causing (R62) to become agitated making contact back. Both residents moved to different tables to prevent further incidents. Both interviewed and both feel safe in facility. Both will remain in facility with no further incidents. Behavior tracking already in place and will continue. MD and POA notified. Care plan updated. There is no progress note noted for this incident. R62's EMR undated documents that the resident was admitted to the facility on [DATE]. R62's EMR dated 7/31/19 documents a diagnosis of undifferentiated schizophrenia. R62's MDS dated [DATE] documents a BIMS score of 13 out of 15. The MDS documents that the resident has not exhibit physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others, or other behavioral symptoms not directed towards others. R62's Care Plan 7/12/24 documents (R62) is at risk for abuse and/or neglect related to DX: Schizophrenia, Major Depression, and Cognitive impairment, psychotropic medication use, poor judgement skills. 02/02/2022 resident was involved in an altercation with peer. 7/5/24 resident was physically aggressive with peer as well as a recipient. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/25 at 12:15 PM, V22, Social Worker stated that if residents are being aggressive with each other than we split them up. We have the residents sign a behavioral contract. With the behavioral contract the resident knows that there are consequences to their actions. The social workers will also do a 1 to 1 psychosocial meeting with the residents. We do behavior tracking on the residents. On 3/14/25 at 12:20 PM, V23, LPN (Licensed Practical Nurse) stated that the first thing she does is contact the administrator if there is an incident between two residents. She stated that the staff will try to de-escalate the situation. We separate the individuals. We are not allowed to touch the residents. We fill out an incident report. We notify the MD (Medical Director) and the guardian or POA. Sometimes we do room moves but that must be approved by administration. She stated they monitor all residents across the board. All residents are treated the same. She stated that with R20 it's all about tone. She stated that he is usually verbally aggressive. She stated that they monitor individuals that are prone to aggression a little closer. Facility's Abuse Prevention Program dated 9/2017 documents This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. This facility therefore prohibits 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 that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents.

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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** 45302 Based on observation, interview and record review the facility failed to assess and document a head to toe skin assessment upon readmission to the facility for 1 (R44) of 1 resident reviewed for pressure wounds in the sample of 39. This failure resulted in the deterioration of the pressure ulcer from a stage II to a stage III. R44's Undated Face Sheet documents initial admitted [DATE] diagnoses of spina bifida and pressure ulcer of sacral region unspecified stage. R44's Annual Minimum Data Set (MDS) dated [DATE] documents she is alert and no pressure ulcers, not at risk for pressure ulcers, no unhealed pressure ulcers. R44's Care Plan, addresses resident at risk for skin complications r/t (related to) skin spina bifida. Goal: area to right buttock will remain stable/heal. Interventions: assess and document progress of areas weekly, assist and encourage resident to turn and reposition every one to two hours and PRN (when needed) and skin assessment weekly. R44's Hospital Discharge Paperwork, dated 8/14/2024 documents sacral stage 2 pressure ulcer. R44's Nurses Note, dated 8/14/2024 at 6:12 PM, documents resident returned to the facility at 6p via ambulance. Resident transferred from stretcher to bed by 2 EMT workers. No c/o pain or discomfort at this time. Resident has a Foley catheter, suprapubic catheter, and cecostomy tube. The resident has a breakdown to her right butt. 97.6 120/74 20 82. Resident laying in bed with call light within reach. No documentation of readmission skin assessment documented. R44's Braden Scale for Predicting Pressure Ulcer Risk dated 8/15/2024 documents moderate risk. R44's Dietary Note, dated 8/15/2024 at 2:59 PM documents resident readmitted on [DATE]. Per staff, resident has 2 pressure wounds on buttocks. Recommend Prostat BID (twice a day) r/t wound healing. R44's NRSG Admission Observation, dated 8/15/2025 documents no skin assessment. R44's Dietary Evaluation, dated 8/15/2024 documents no skin issues and recommend Prostat 30 ml (milliliters). R44's Medication Administration Record (MAR) dated 8/15/2024 documents no physician's order for Prostat BID. R44's Treatment Administration Record (TAR), dated 8/17/2024 through 8/31/2024 documents staff initial treatment administered to buttocks one time a day and PRN to promote wound healing calcium alginate, medihoney wound gel and foam bordered dressing. R44's Skin Screen dated 8/20/2024 documents stage 3 pressure ulcer. No other assessment documented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R44's Wound Evaluation, dated 8/20/2024 documents stage 3 pressure ulcer right ischial tuberosity 6 days old present on admission measured 6.11 centimeters (cm) x 3.01 cm x 2.77 cm. Wound bed assessment: 60% slough, 40% eschar, no exudate (drainage), periwound area attached, surrounding tissue intact. R44's Wound Assessment Report, dated 8/21/2024 documents right ischium Stage 3 pressure ulcer date wound acquired 8/14/2024, present on admission. Wound status: 90% granulation, 10% slough, wound edges attached, periwound: intact, exudate: moderate, exudate amount: serosanguineous drainage, no odor. Treatment: daily and PRN (when needed) cleanse with wound cleanser, medical grade honey, collagen particles, calcium alginate and bordered foam. R44's Physician's Order Sheet (POS), dated 8/2024 documents staff administered wound treatment start date 8/16/2024 calcium alginate, medihoney and a foam dressing apply to buttocks topically one time a day/PRN (when needed) to promote wound healing. No physician's order for Prostat 30 ml twice a day documented. R44's POS dated 9/2024 documents a physician's order dated 9/4/2024 Prostat two times a day for wound healing 30 ml. Staff documented it was administered 9/5/2024 through 9/30/2024. On 3/12/2025 at 8:36 AM V12, Wound Nurse/LPN provided wound care to R44. V12 entered room washed hands and donned gloves. He assisted R44 to roll to her left side and removed the intact dressing to her right buttocks/ischium area. Wound bed was approximately 30% slough and had serosanguinous drainage that measured approximately 4.0 centimeters (cm) x 5 cm. No concerns regarding infection control noted during treatment. R44 lying on a low air loss mattress and had a wedge pillow under her left side. The Facility's Pressure Injuries Policy, last reviewed date 4/2024 the facility will ensure that all residents have necessary assessments completed in a timely manner at the point of admission in order to provide the best possible, person-centered care. All new and re-admissions that have been out of the facility longer than 24 hours should be assessed within 1 day of arriving to the facility by a licensed nurse to ensure stability and safety of resident. Within 24 hours of admission, the following forms should be completed NRSG: Admission Observation, Braden's Scale for Predicting Pressure Sore Risk and NRSG: Interim Baseline Care Plan.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 45302 Based on observation, interview and record review, the facility failed to employ a full-time Director of Nurses DON to oversee the facility's nursing department. This failure has the potential to affect all 126 residents residing in the facility. Findings include: On 3/11/2025 at 9:05 AM V6, Registered Nurse Consultant stated the facility does not have a Director of Nurses at this time and the Assistant Director of Nurses (ADON) just started working at the facility a day ago. On 3/13/2025 at 3:16 PM V6, Registered Nurse Consultant stated the former DON's last day was 2/11/2024. Facility Assessment Tool dated 3/5/2025 documents, no name for the Director of Nurses on the Facility Assessment Tool. Resident Census and Conditions of Residents form CMS-671 dated 03/11/2025 documents a census of 126. The Facility's Nursing Services - Registered Nurse RN Policy last reviewed 9/2024, documents it is the intent of the facility to comply with registered nurse staffing requirements. The facility will designate a registered nurse to serve as the Director of Nursing on a full-time basis. The Director of Nursing may serve as a charge nurse only when the facility has average daily occupancy of 60 or fewer residents.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 25071 Based on observation, interviews, and records review, it was determined that the facility failed to ensure garbage in the facility dumpster was covered. This has the potential to affect all 126 residents residing in the facility. The findings include: Review of the facility's policy Disposal of Garbage and Refuse with a review date of 10/2024, revealed, Procedure: 1. The facility will assure all garbage and refuse containers are in good condition (no leaks) and waste is properly contained in dumpsters or compactors with lids and covered. Observation on 03/11/2025 at approximately 09:03 AM revealed two dumpsters for garbage located behind the kitchen. One dumpster lid was missing while the second lid was completely open to the environment and observed to be approximately half full of garbage bags and other trash. During an interview on 03/11/2025 at approximately 09:03 AM, V21 Dietary Aide verified the observation and stated These lids should be closed. That is how we keep the animals out of the trash. During an interview on 03/12/2025 at 12:50 PM V1 Administrator stated The operator of the garbage truck ripped the lid off and never worried about replacing it. I've contacted the company and was told they will replace the entire unit.