STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER Belleville Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2626 Wesleyan Dr Belleville, KS 66935	

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 58 residents. The sample included three residents, with three reviewed for abuse. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 2 remained free from misappropriation of her property. This placed the resident at risk for ongoing misappropriation and impaired psychosocial well-being. Findings included: - The Electronic Medical Record (EMR) for R2 documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), pain, hypertension (high blood pressure), and weakness. The Admission Minimum Data Set (MDS) dated [DATE] documented a resident interview where R2 indicated choosing her own clothes, and taking care of her personal belongings or things was very important to her. The Quarterly MDS dated [DATE] documented R2 had moderately impaired cognition. R2 required supervision with upper body dressing and personal hygiene. R2 required partial assistance with toileting, mobility, lower body dressing, and transfers. R2 did not ambulate. R2's Care Plan, dated 08/16/24 and initiated on 11/29/23, documented R2 had impaired cognition and directed staff to cue, reorient, and supervise as needed. The plan directed staff to administer medications as needed, engage in simple, structured activities that avoid overly demanding tasks, and monitor for any changes in R2's cognition. R2's Inventory Sheet, dated 12/11/23 documented R2 had a gold diamond ring. The facility Investigation Report, dated 10/29/24, documented that staff reported to Administrative Nurse D that R2's wedding ring was missing from her finger. R2's knuckle on the ring finger was very large and the ring would not have been able to fall off. R2 reported to staff that someone sprayed something on her finger, and took the ring, and her finger had hurt for a few days. R2 could not remember who or when this occurred. Administrative Nurse D searched R2's room, interviewed and obtained witness statements of all staff who had worked that day and the previous night. The facility was searched by leadership staff and the ring was not located. The facility contacted local Law Enforcement (LE) and statements were given. The facility conducted a staff in-service for Abuse Neglect and Exploitation. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 08:30 AM, observation revealed that R2 sat in her recliner and received a breathing treatment. On 11/13/24 at 09:00 AM, Social Service X stated she received a call to see if she had locked up R2's wedding ring as it was missing from R2's finger. Social Service X stated she had not locked up the ring and could not remember when she had last seen the ring. Social Service X stated she, Administrative Nurse D, and Administrative Staff A searched R2's room, her roommate's belongings, and the laundry but they were unable to locate the ring. Social Service X stated that when R2 was first admitted to the facility, she asked R2's family to take the ring home but several family members could not get the ring off her finger, so they left it on her finger. Social Service X stated that during the recent care plan meeting R2, who was cognitively impaired, told them again that someone had taken the ring but could not pinpoint when it happened. Social Service X stated when residents were admitted to the facility with anything of value like expensive jewelry, she asked the family to take it home or keep it in the facility lockbox. On 11/13/24 at 9:19 AM, Administrative Nurse D stated she had been notified by a staff member that they could not locate R2's wedding ring and she had thought it was in the facility lock box because someone had found a ring, but it was not R2's wedding ring. Administrative Nurse D interviewed staff and searched R2's room, and the recliner in the living room area she always sat in. Administrative Nurse D said staff took apart the plumbing to the sink but were still unable to locate the ring. Staff filled out witness statements, and agency staff were notified that a statement would need to be filled out as soon as possible. Administrative Nurse D stated the two agency staff members who had worked at the facility declined to come in and write statements and then canceled all their upcoming shifts. LE was notified and a report with all the information as well as the two agency staff members was provided to the police. A picture of the ring was also provided to the police department. On 11/13/24 at 9:30 AM, Administrative Staff A stated he searched the resident's room as well as the roommates' possessions, and recliners, and took apart the washing machine and sink plumbing in the hope that the ring was there. Administrative Staff A stated they interviewed staff and contacted the police to start an investigation. Administrative Staff A stated the facility would rather the family take valuables with them or keep them in their lockbox, just so they are not faced with this kind of situation. On 11/13/24 at 2:30 PM, Certified Nurse Aide (CNA) M stated she had only worked at the facility for a few days and was unaware of the missing ring. On 11/13/24 at 02:45 PM Licensed Nurse H stated she had seen R2's wedding ring when she would do her assessments but could not remember when the ring was last on her finger and did not know what happened to it. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Personal Property undated policy, documented, that this facility understands the value and importance of everyone's personal property. The loss of valuable personal property is an unfortunate event and a very difficult task to manage in a long-term care facility where many diverse residents reside and employees work, there are many valuables to control including the presence of confused and/or ambulatory residents, multiple occupancy rooms, visitation by friends and relatives, and residents who frequently leave the facility. By defining an approach to investigate complaints of theft or misplaced personal property, the administration wishes not only to discover lost items but also to gather information and determine potential patterns that may lead to the reduction and eventual prevention of lost items or theft. The facility's The Resident's Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure, undated, documented the residents have the right to be free from abuse, neglect, misappropriation of their property, and exploitation. This includes but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This policy applies to any owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the company. The facility failed to protect R2 from misappropriation of resident property after staff failed to safeguard R2's wedding ring, which had to be physically removed, went missing. This placed the resident at risk for further loss of property and psychosocial decline.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360 The facility had a census of 58 residents. The sample included three residents. Based on observation, record review, and interview, the facility failed to ensure adequate infection control measures for Resident (R) 1 during wound care, when staff did not change her gloves after she cleansed the wound. This placed the resident at risk for continued wound infection and complications. Findings included: - The Electronic Medical Record (EMR) for R1 documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypertension (high blood pressure), open lesion (wound or injury), and cellulitis of the foot (skin infection caused by bacteria). The Quarterly/Medicare 5 Day Minimum Data Set (MDS), dated [DATE], documented that R1 had intact cognition. R1 required set-up assistance with eating, bathing, personal hygiene, and transfers. The MDS documented R1 was at risk for pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), had an infection of the foot, and had application of ointment and dressings to the feet. R1's Care Plan, dated 08/15/24 and initiated on 07/28/21, directed staff to observe and assess her skin weekly, refer to the dietician with skin concerns and supplement with vitamins as indicated. The update, dated 10/25/24, directed staff to promote good nutrition and hydration, document weekly treatments including measurements of each area of skin breakdown, and follow facility protocols for treatment of injury. R1's Physician's Order, dated 10/28/24, directed staff to cleanse the open lesion to the bottom of her right foot with Hibiclens (antiseptic skin cleanser used to prevent skin infections) and water, apply Triple Antibiotic Ointment (TAO-a antibiotic ointment used to prevent and treat minor skin infections) to the open area, apply an ABD pad (large pad to absorb drainage), and wrap with Kling (a sterile, flexible, rolled gauze bandage used to secure gauze pads or nonstick dressings), every day shift for the right foot wound. On 11/13/24 at 3:03 PM, observation revealed R1, in her recliner, with her feet elevated. Licensed Nurse (LN) G sanitized her hands, donned a clean gown and gloves, placed a barrier under R1's right foot, and removed the soiled dressing. The dressing had brown drainage visible which had soaked through the dressing and LN G placed it in a red bag. LN G then removed her soiled gloves, performed hand hygiene, and donned clean gloves. LN G used her tablet to take pictures of the wound and also took R1's phone to take pictures of the wound for the resident. Wearing the same gloves, LN G cleansed the wound with wound cleanser. LN G applied a small amount of TAO directly onto R1's wound wearing the same soiled gloves and then placed a fresh ABD pad on it and wrapped R1's foot with the Kling. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 3:10 PM, LN G stated she measured the wound weekly and the dressing was changed daily. LN G stated she should have changed her gloves after she cleansed the wound. On 11/13/24 at 03:30 PM, Administrative Nurse D stated LN G should have changed her gloves after she cleansed the wound. The facility's Infection Control Preventing Spread of Infection undated policy, documented the facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility administration and medical director should ensure that current standards of practice based on recognized guidelines are incorporated into the resident care policies and procedures. These practices must include hand hygiene before and after changing a dressing. The facility failed to ensure adequate infection control measures during wound care for R1, who had a recent infection in her right foot wound, This placed the resident at risk for continued infection and complications.