STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175246	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belleville Healthcare and Rehabilitation Center	2626 Wesleyan Dr Belleville, KS 66935

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 34 residents with three residents reviewed for unintended weight loss. Based on record review, observation, and interview, the facility failed to obtain consistent weights to establish a baseline, failed to identify and respond to progressive weight loss with intervention and increased assistance, and failed to follow the Registered Dietician (RD) recommendations to provide nutritional support for Resident (R)1. Subsequently, R1 had a significant unintended weight loss. This deficient practice also placed R1 at risk for decreased nourishment and delayed wound healing. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), major depressive disorder (major mood disorder which causes persistent feelings of sadness), hyponatremia (lower than normal concentration of sodium in the blood), and anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). R1's Admission Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The MDS documented R1 had an impaired range of motion in both of her upper extremities and both of her lower extremities. R1 required moderate assistance from staff with eating. R1's admission weight was 191 pounds (lbs.). R1 was on a mechanically altered and therapeutic diet and had no natural teeth or tooth fragments. The MDS documented R1 was dependent on staff for toileting, bathing, dressing, bed mobility, and transfers. The Nutritional Status Care Area Assessment (CAA), dated 09/16/24, documented R1's nutritional status would be addressed in her care plan. The CAA directed staff to monitor R1's body weight every week to help monitor trends in body weight. The CAA directed staff to monitor intrinsic factors, such as pain or functional mobility, that could affect her food and fluid intake. The CAA documented the registered dietitian was to meet with R1 regularly to help ensure R1's nutritional needs were met. The Pressure Ulcer/Injury CAA, dated 09/16/24, documented pressure ulcers (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) would be addressed on R1's Care Plan. The CAA directed staff to help maintain R1's skin integrity with repositioning per protocol and as needed. The CAA directed licensed nursing staff to monitor R1's skin integrity weekly and monitor for any skin issues. (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 0692 Level of Harm - Actual harm Residents Affected - Few	The Functional Abilities CAA, dated 09/16/24, directed staff to assist with activities of daily living (ADLs) and anticipate care, as needed, so that R1's care needs were effectively met. R1's Care Plan documented R1 used specialty devices of a wheelchair and a Hoyer lift (total body mechanical lift) (09/16/24). The care plan documented R1 as at risk for skin breakdown based on risk scale assessment and had a coccyx (area at the base of the spine) pressure wound present on admission and a pressure injury to her right buttock area, facility acquired on 11/17/24. The care plan documented R1 was to use an air mattress to assist with wound healing and prevention measures for future skin breakdown (09/17/24). The care plan documented R1 would use a Broda chair (specialized wheelchair with the ability to tilt and recline) (12/10/24). Encourage good nutrition and hydration to promote healthier skin (12/10/24). The care plan directed staff to get R1 up right before meals and lay down as soon as possible after eating to aid in wound healing (12/10/24). The care plan directed staff to ensure R1 had adequate protein intake, supplement R1 with vitamins when indicated, and refer to the RD with skin concerns (09/16/24). The care plan directed staff R1 required setup or clean-up assistance for eating (10/01/24). The care plan documented R1 was dependent on staff for oral hygiene, toileting, bathing, dressing, transfers, and bed mobility (10/01/24). The care plan documented R1 was on Enhanced Barrier Precautions (EBP) due to a wound and directed staff to don personal protective equipment while providing care to the affected area (10/17/24). The care plan documented R1 had multiple significant Stage 4 (a deep pressure wound that reaches the muscles, ligaments, or even bone) wounds that required increased nutrient needs for wound healing demands, notify RD and nursing if there was a change in baseline for intake of food or beverages, and provide nutrition and supplements, as ordered (12/10/24). The Hospital Health and Physical (H&P) dated, 09/09/24, documented R1's weight was 188.5 lbs. The H&P documented R1 was bed-bound at her baseline, required a mechanical lift for transfers, and required maximum to moderate assistance by therapies for ADLs. R1 required total assistance for mobility with contractures (abnormal fixation of a muscle or joint) noted. Speech therapy recommended a mechanically altered diet with nectar thick liquids, as R1 was noted to pocket foods and was on aspiration precautions. Dietary was consulted due to moderate protein-calorie malnutrition. R1's Dismissal Instructions, dated 09/13/24, documented the transfer to the nursing facility and directed R1 resume her home diet, resume activity as tolerated, and included a treatment plan for R1's closed Stage 4 pressure injury as follows: cleanse wound with gentle flush and pat dry, apply moisture barrier cream to peri-wound, apply Sorbact (wound dressing) to the wound and cover with a foam dressing, change two times weekly on Monday and Thursday; float heels with pillows lengthwise or utilize Prevalon boots (specialized pressure reliving boots) at all times, even when sitting in a chair; monitor bilateral heels to ensure closed pressure injuries remain intact; air mattress with turning regimen of at least every two hours at 30-degree intervals; when sitting up in chair limit to one-hour intervals, and ensure a chair cushion was in place. The Admission Assessment, dated 09/13/24 documented R1 arrived at the facility via wheelchair. The reason for R1's admission was weakness and wound care. R1's weight was 191.2 pounds. R1 was oriented to the call light and bed controls. R1's skin was normal for ethnicity. R1 had full upper and lower dentures. R1 was alert and oriented to person, place, and time. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The Admission Summary Note, dated 09/13/24, documented the facility received the report from the hospital nurse. The note documented R1 had been on aspiration precautions and had admitted to the hospital on 09/04/24 for sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) and failure to thrive. R1 was on a mechanically altered diet with honey thick liquids. R1 had a Stage 4 closed pressure wound on her coccyx with dressing changes every 72 hours. Staff would float heels and turn every two hours. R1 was bedridden and needed Prevalon boots on. The Multidisciplinary Care Conference Note, dated 09/13/24, documented R1 needed extensive assistance with ADLs, used a Broda chair for mobility propelled by staff, and a full body lift for transfers. For the dietary section, R1 weighed 191 lbs., had bilateral lower extremity edema, received Lasix (a diuretic used to promote urine excretion and reduce swelling), and had a body mass index (BMI) of 32.8 which indicated obesity. R1 was on a controlled carbohydrate and mechanical soft diet, with nectar-thickened liquids, due to DM and dysphagia (difficulty swallowing). R1 had a fair appetite with variable intakes. The note documented R1 did not eat meat per her preference, and she was able to feed herself after set-up and assist as needed. The note documented staff would anticipate weight fluctuations due to fluid shifts and noted a gradual weight loss was desirable given R1's obesity. The Weights and Vitals Tab, dated 09/13/24, documented R1's weight was 191.2 pounds. This value was crossed out as disputed by licensed nursing staff on 10/21/24. The initial Nutritional Assessment Note, dated 09/19/24, documented R1 admitted post sepsis with an admission height of 64 inches and a weight of 191 pounds. R1 had bilateral lower extremity edema (swelling) with a diagnosis of CHF and received Lasix. R1's body mass index was 32.8 which indicated obesity. R1 had weekly weights in place. R1 tolerated the current diet, she had a fair appetite with variable meal intakes, and she did not eat meat per her preference. R1 was able to feed herself after set-up; staff would assist as needed. R1 had skin concerns on her coccyx and a scab on her second toe. R1 was at nutritional risk due to infection, obesity, the potential for weight fluctuations due to fluid shifts, DM, and the need for a therapeutic diet. Other risks included dysphagia, variable intakes, and skin concerns. The RD indicated staff would continue to monitor R1's weekly weights and would anticipate weight fluctuations due to fluid shifts. A gradual weight loss was desirable given R1's obesity. Staff were to follow speech therapy recommendations, continue to encourage intake, and follow her food preferences. The RD recommended encouraging protein for wound healing, strengthening, and blood sugar control. The Weights and Vitals Tab, dated 09/26/24, documented R1's weight was 190.4 pounds. This value was crossed out as disputed by licensed nursing staff on 10/21/24. The Weights and Vitals Tab, dated 10/13/24 (2.5 weeks after the last weight), documented R1's weight was 161.2 pounds. The Weights and Vitals Tab, dated 10/20/24, documented R1's weight was 160.7 pounds. This value was crossed out as disputed by licensed nursing staff on 10/21/24. The Weights and Vitals Tab, dated 10/21/24, documented R1's weight was 160.7 pounds. The Weights and Vitals Tab, dated 10/27/24, documented R1's weight was 165 pounds. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	R1's meal intake monitoring was requested from the facility. The facility provided part of November 2024, from 11/17/24 through 11/26/24. The documentation had three meals with no percentages documented, four days where R1 ate 26-50% of her meals, fourteen days she ate 51-75% of her meals, and eight days she ate 76-100% of her meals. The facility was unable to provide any other meal intake records for October or November. The Weights and Vitals Tab, dated 11/12/24, documented R1's weight was 152 lbs. This value was crossed out as disputed by licensed nursing staff on 12/15/24. The Nutrition/Dietary Note, dated 11/15/24, documented a nutrition review was completed related to R1's wound. R1 had a Stage 4 pressure ulcer to her coccyx and required increased nutrient needs for healing. R1 was eating 50-100% of her meals on a mechanical soft consistent carbohydrate diet with honey-thickened liquids. The RD recommended ordering 30 milliliters (ml) of liquid protein to provide R1 with 200 kilocalories and 30 grams of protein for wound healing demands. The note recorded the RD would monitor and follow up as needed. R1's Medication Administration Record (MAR) and/or Treatment Administration Record (TAR) lacked any orders for 30 ml of liquid protein for wound healing demands. The Weights and Vitals Tab, dated 11/16/24, documented R1's weight was 152.8 pounds. This value was crossed out as disputed by licensed nursing staff on 12/15/24. The Weights and Vitals Tab, dated 11/23/24, documented R1's weight was 162.4 pounds. Meal Percentages for December 2024 from 12/07/24 through 12/16/24 documented R1 had two meals where no percentages were documented, three meals she ate 0-25% of her meal, five meals she ate 26-50% of her meal, seven meals she ate 51-75% of her meals, and ten meals she ate 76-100% of her meals. The Nutritional Assessment Note, dated 12/10/24, documented R1 had significant deterioration of wounds with infection present, was on antibiotics, and had multiple Stage 4 pressure ulcers. R1 required increased protein/kilocalorie needs as her intake at meals were inadequate to meet her increased needs. Recommendations included modifying R1's diet to regular/mechanical soft with honey-thickened fluids, ordering 60 ml of liquid protein twice a day, ordering fortified foods with meals, and monitoring intakes, labs, wound status, and follow-up as needed. On 12/11/24, R1's December 2024 MAR documented an order for a Prenatal Vitamin, one tab daily, for wound healing per the facility's request. On 12/12/24, R1's MAR documented Prostat (liquid protein) 60 ml twice a day was ordered for wound healing. Upon the surveyor's request, the facility weighed R1 on 12/17/24. R1's weight was 154 pounds. On 12/17/24 at 09:30 AM, observation revealed R1 laid in bed on her left side with covers over her. R1's water pitcher was back on a bedside table, unreachable for R1. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 12/17/24 at 10:30 AM, observation revealed a dressing change performed to R1's right Stage 4 pressure ulcer. The removed dressing was saturated with serosanguineous (semi-thick blood-tinged drainage) drainage. The pressure area had a large amount of gray eschar (dead tissue) and a moderate amount of cream-colored slough (dead tissue, usually cream or yellow in color). Licensed Nurse (LN) G and Certified Nurse Aide (CNA) M donned gloves but no gowns and CNA M held R1 over to her left side while LN G cleansed the wound, cut the dressing to fit the wound, and then covered the wound with a bordered dressing. R1 did complain of pain during the dressing change. The staff did not measure R1's wound. On 12/17/24 at 11:40 AM, R1 stated she could not feed herself all the time because she got so tired. She also stated staff did not help her eat or drink at mealtime. R1 stated she was not always offered water to drink with care and when she asked for water staff did not hear her. On 12/17/24 at 09:35 AM, Certified Medication Aide (CMA) R stated R1 came to the facility with pressure ulcers. CMA R stated R1 required turning and repositioning and required assistance with eating her food at mealtimes. On 12/17/24 at 11:30 AM, CNA M stated R1 required assistance with eating sometimes, but generally was able to eat by herself after the meals were set-up. CNA M stated there was no turning schedule for R1 and charting on turning was only every shift. CNA M stated the aides just kept R1's turning schedule in their heads and turned her when it was time. On 12/17/24 at 01:00 PM, RD GG stated it was not unusual for the first weight after admission to a facility to be wrong. RD GG stated she saw the first several weights were struck out by the nursing staff. RD GG stated she had not requested new weights to be obtained. RD GG stated baseline weights on new admissions should be obtained weekly for the first four weeks. RD GG verified baseline weights on R1 were not obtained by the facility. RD GG stated she did not realized that her first recommendation for additional protein had not been ordered for R1 until she reviewed R1's weights and wounds in December and made additional recommendations. On 12/17/24 at 01:30 PM, Administrative Nurse D stated it was the facility's policy to obtain weights on new admissions for the first four weeks after a resident was admitted to the facility, to obtain a baseline. Administrative D stated residents on skilled care were weighed weekly and verified R1 had been on skilled care for strengthening and therapy. Administrative Nurse D stated all of the weights were reviewed weekly and she did not know why R1's weights were not obtained but it probably had to do with agency staff not charting the weights. Administrative Nurse D stated nursing staff did not see RD GG's order in November for liquid protein to be added to R1's MAR and verified R1 did not start receiving liquid protein for increased protein intake and wound healing until 12/12/24. Administrative Nurse D also verified a multivitamin had not been ordered for wound healing until 12/11/24. Administrative Nurse D stated R1's plan of care did state R1 did not eat meat per her choice, but she had talked to dietary staff, and they stated R1 did eat meat. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The facility's Weight Monitoring Policy, dated 10/30/24, documented based on the resident's comprehensive assessment, the facility will ensure that residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated that this is not possible or resident preferences indicate otherwise. Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight (gradual unintended weight loss over a period) may indicate a nutritional problem. The facility will utilize a systemic approach to a resident's nutritional status. This process includes identifying and assessing each resident's nutritional status and risk factors, evaluating, and analyzing the assessment information, developing, and consistently implementing pertinent approaches, monitoring the effectiveness of interventions, and revising when necessary. Implementation gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's nutritional concerns and preferences. Interventions will be identified, implemented, monitored, and modified consistent with the resident's assessed needs, choices, preferences, goals, and current professional standards to maintain acceptable parameters of nutritional status. A weight monitoring schedule will be developed upon admission for all residents. Weights should be recorded at the time obtained. The newly admitted resident's weight will be monitored weekly for four weeks. Residents with weight loss weights will be monitored weekly. If clinically indicated monitor weight daily. All others monitor weight monthly. The newly recorded resident weight should be compared to the previously recorded weight. A significant change in weight is defined as: a 5% change in weight in 1 month, a 7.5% change in weight in three months, and a 10% change in weight in six months. The physician should be informed of a significant change in weight and may order nutritional interventions. The physician should be encouraged to document the diagnosis or clinical conditions that may be contributing to weight loss. Meal consumption information should be recorded and may be referenced by the interdisciplinary team as needed. If the interdisciplinary team desires to explore specific meal consumption information for a resident the RD or Dietary Manager, or the nursing department may initiate this process. The RD or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition process notes. Observations pertinent to the resident's weight status should be recorded in the medical record. The interdisciplinary team communicated care instructions to staff. The facility failed to obtain consistent weight to establish a baseline, failed to identify and respond to progressive weight loss with interventions and increased assistance, and failed to follow the RD's recommendations to provide nutritional support for R1. Subsequently, R1 had a 19.5 % significant weight loss in ninety-five days from her admission on 09/13/24. This deficient practice also placed R1 at risk for decreased nourishment and delayed wound healing.

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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. 43204 The facility identified a census of 34 residents. The facility identified 11 residents on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care). Based on record review, observation, and interview, the facility failed to ensure staff implemented targeted gown and glove use during the high-contact care of a resident with a wound infection during a dressing change. This deficient practice placed the resident at risk for infectious diseases. Findings included: - On 12/17/24 at 10:30 AM, Licensed Nurse (LN) G and Certified Nurse's Aide (CNA) M entered R1's room to perform a dressing change to the resident's buttocks. LN G and CNA M did not don a gown for the dressing change. LN G and CNA M entered R1's room, donned gloves only, and performed the dressing change. CNA M held R1 over to her left side while LN G cleansed the wound, cut the dressing to fit the wound, and then covered the wound with a bordered dressing. R1 did complain of pain during the dressing change. No measurements were taken of R1's wound. On 12/17/24 at 10:45 AM, LN G stated she had forgotten the resident was on EBP and verified she had not donned a gown prior to performing the resident's dressing change. On 12/17/24 at 11:30 AM, CNA M verified she had not donned a gown prior to assisting LN G with the resident's dressing change. On 12/17/24 at 01:30 PM Administrative Nurse D stated LN G had come to her after the dressing change and told her she had forgotten to don a gown prior to performing the dressing change. Administrative Nurse D verified R1 was on EBP for the wound on R1's buttocks. Administrative Nurse D stated there were a total of 11 residents on EBP. Administrative Nurse D stated the staff should have donned gowns and gloves prior to completing the resident's wound care. The facility's Enhanced Barrier Precautions Policy, dated 04/01/24, documented it is the policy of this facility to implement EBP for the prevention of transmission of multi-drug resistant organisms. All staff will receive training upon hire and at least annually and are expected to comply with all designated precautions. The facility will make gowns and gloves available immediately near or outside of the resident's room. Personal protective equipment (PPE) for enhanced barrier precautions is only necessary when performing high-contact care activities. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside the room). Position trash can inside the resident room or near the exit for discarding PPE after removal prior to exit of the room or before providing care for another resident in the same room. The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. The facility failed to ensure staff wore a gown during the high-contact care of a resident with a wound infection during a dressing change. This deficient practice placed the resident at risk for infectious diseases.