STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)5) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1	S9999		

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

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.

These requirements are not met as evidenced by:

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 admission date 4/17/2020 diagnoses of spina bifida and pressure ulcer of sacral region unspecified stage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2	S9999		

R44's Annual Minimum Data Set (MDS) dated 6/24/2024 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 8/14/2024. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3 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. 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.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4	S9999		

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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001341	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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5 Braden's Scale for Predicting Pressure Sore Risk and NRSG: Interim Baseline Care Plan. (B)	S9999		