(X6) DATE

Illinois Department of Public Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1` 'c			SURVEY LETED		
7.1.12 1 27.11	BEATT TO THE TENT OF THE PARTY.		A. BUILDING:		33 LE1EB			
IL6001341			B. WING		03/1	03/14/2025		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
BELLEV	LLE HEALTHCARE C	:FNTFR	「H 17TH STF _LE, IL 6222					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE		
S 000	Initial Comments		S 000					
	Annual Licensure S	Survey						
S9999	Final Observations		S9999					
	Statement of Licens	sure Violations:						
	300.610a) 300.1210b) 300.1210d)5)							
	Section 300.610 R	esident 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 ( Nursing and Persor	General Requirements for nal Care						
	care and services to practicable physica well-being of the re- each resident's con plan. Adequate and care and personal of	shall provide the necessary o attain or maintain the highest I, mental, and psychological sident, in accordance with aprehensive resident care I properly supervised nursing care shall be provided to each e total nursing and personal esident.						

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/28/25 **Electronically Signed** 

TITLE

STATE FORM 6899 If continuation sheet 1 of 6 A6LQ11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6001341	B. WING		03/	14/2025
	PROVIDER OR SUPPLIER	SENTER 727 NOR	DDRESS, CITY, ST TH 17TH STRI LLE, IL 62226	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
\$9999	d) Pursuant to nursing care shall in following and shall seven-day-a-week  5) A regular propressure sores, head breakdown shall be seven-day-a-week enters the facility would develop pressure sores were unavoid pressure sores were unavoid pressure sores shaservices to promote and prevent new properties to the facility for a head to toe skin at to the facility for 1 (for pressure wound failure resulted in the facility for a head to toe skin at the facility for a head to toe skin at the facility for a head to toe skin at the facility for 1 (for pressure wound failure resulted in the facility for 1 (for pressure wound failure resulted in the facility for 1 (for pressure wound failure resulted in the facility for 1 (for pressure wound failure resulted in the facility for 1 (for pressure wound failure from a stage).	subsection (a), general nclude, at a minimum, the be practiced on a 24-hour, basis:  rogram to prevent and treat at rashes or other skin practiced on a 24-hour, basis so that a resident who ithout pressure sores does not ores unless the individual's emonstrates that the pressure lable. A resident having all receive treatment and enhealing, prevent infection, ressure sores from developing. It is not assess and document assessment upon readmission R44) of 1 resident reviewed as in the sample of 39. This ne deterioration of the pressure lable to assess and document assessment upon readmission R44) of 1 resident reviewed as are not met as evidenced by an interview and record failed to assess and document assessment upon readmission R44) of 1 resident reviewed as in the sample of 39. This ne deterioration of the pressure as edeterioration of the pressure and deterioration of the pressure and the pressure as a substant				

Illinois Department of Public Health

STATE FORM 6899 A6LQ11 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
IL6001341		B. WING		03/14/2025		
	PROVIDER OR SUPPLIER	FNTER 727 NORT	DRESS, CITY, S TH 17TH STF LLE, IL 6222		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CORRECTION (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 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.					
	documents "resider via ambulance. Res stretcher to bed by discomfort at this til catheter, suprapubit tube. The resident I butt. 97.6 120/74 20 with call light within	dated 8/14/2024 at 6:12 PM, at returned to the facility at 6p sident transferred from 2 EMT workers. No c/o pain or me. Resident has a Foley c catheter, and cecostomy has a breakdown to her right 0 82. Resident laying in bed reach." No documentation of ssessment documented.				
		e for Predicting Pressure Ulcer 24 documents moderate risk.				
	documents resident staff, resident has 2	dated 8/15/2024 at 2:59 PM t readmitted on 8/14/2024. Per 2 pressure wounds on end Prostat BID (twice a day)				
	R44's NRSG Admis	ssion Observation, dated				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
	IL6001341		B. WING		03/14/2025		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
BELLEV	ILLE HEALTHCARE C	:FNTFR	TH 17TH STF LLE, IL  6222				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 3	S9999				
	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.						
	8/21/2024 document pressure ulcer date present on admissing granulation, 10% sliperiwound: intact, eamount: serosangut Treatment: daily and cleanse with wound	ssment Report, dated nts right ischium Stage 3 wound acquired 8/14/2024, on. Wound status: 90% ough, wound edges attached, exudate: moderate, exudate iineous drainage, no odor. d PRN (when needed) d cleanser, medical grade rticles, calcium alginate and					

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  727 NORTH 17TH STREET  BELLEVILLE HEALTHCARE CENTER  SUMMARY STATEMENT OF DEFICIENCES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 4  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, mediboney and a foam dressing apply to buttocks.	(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
BELLEVILLE HEALTHCARE CENTER  727 NORTH 17TH STREET BELLEVILLE, IL 62226  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999 Continued From page 4  R44's Physician's Order Sheet (POS), dated 8/2024 documents staff administered wound treatment start date 8/16/2024 calcium alginate,		IL6001341					
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE 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,	REET	TH 17TH STI	BELLEVILLE HEALTHCARE CENTER 727 NORT				
R44's Physician's Order Sheet (POS), dated 8/2024 documents staff administered wound treatment start date 8/16/2024 calcium alginate,	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		
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 y all icensed nurse to ensure stability and safety of resident. Within 24 hours of admission, the following forms should be		S9999	order Sheet (POS), dated staff administered wound 8/16/2024 calcium alginate, am dressing apply to buttocks day/PRN (when needed) to aling. No physician's order for a day documented.  2024 documents a steed 9/4/2024 Prostat two and healing 30 ml. Staff administered 9/5/2024  36 AM V12, Wound downed gloves. For the facility will ensure that the entimeters (cm) x 5 cm. No infection control noted during gon a low air loss mattress allow under her left side.  37 Use of the facility will ensure that the ecessary assessments are loss possible, and re-admissions of the facility longer than 24 sessed within 1 day of arriving censed nurse to ensure of resident. Within 24 hours of the resident. Within 24 hours of the facility within 24 hours of the facility.	R44's Physician's C 8/2024 documents streatment start date medihoney and a fot topically one time a promote wound hear Prostat 30 ml twice  R44's POS dated 9/physician's order datimes a day for wou documented it was through 9/30/2024.  On 3/12/2025 at 8:3 Nurse/LPN provided entered room wash. He assisted R44 to removed the intact obuttocks/ischium ar approximately 30% serosanguinous dra approximately 4.0 c concerns regarding treatment. R44 lying and had a wedge pi  The Facility's Press reviewed date 4/202 all residents have nompleted in a time admission in order to person-centered cathat have been out hours should be assito the facility by a lice stability and safety of	S9999		

Illinois Department of Public Health

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMP	SURVEY		
		IL6001341	B. WING		03/1	4/2025		
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE	1 00/1	412020		
BELLEVILLE HEALTHCARE CENTER 727 NORTH 17TH STREET BELLEVILLE, IL 62226								
BELLEVII				PROVIDER'S PLAN OF CORRECT	ION	()(5)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
S9999	Continued From pa	ge 5	S9999					
	Braden's Scale for I and NRSG: Interim	Predicting Pressure Sore Risk Baseline Care Plan.						
	(B)							

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