STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058438	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA BELLA OF ALTON	3490 HUMBERT ROAD , ALTON, Illinois, 62002

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S0000	Initial Comments Complaint Investigation: 2568594/2546709	S0000		08/15/2025
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 300.1210d)6) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective	S9999		08/15/2025

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

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S9999	Continued from page 1 resident care plan. 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on interview, observation, and record review the facility failed to implement a resident's bed mobility care plan for 1 of 5 residents (R2) reviewed for falls in the sample of 7. This failure resulted in R2 falling from R2's bed and sustaining a raised hematoma above the left eye, bruising below the left eye, bruising behind the left ear, bruising covering the left side of R2's neck and multiple bruises covering the left side of R2's face. Findings Include: R2's face sheet, dated 7/24/25, documented R2 has diagnoses including Alzheimer's disease, chronic embolism, and thrombosis of left femoral vein, type 2 diabetes, vascular dementia, hyperlipidemia, and hypertension. R2's MDS (Minimum Data Set), dated 4/16/25, does not have a cognition score documented. On 7/24/25 at 1:52 PM surveyor asked V1, Administrator, since R2's cognitive impairment test score is blank does that indicate R2 is severely cognitively impaired and V1 replied yes. R2's MDS, dated 4/16/25, documented R2 is dependent on staff for bed mobility and requires a mechanical lift for transfers. R2's care plan, undated, documented bed mobility: the resident needs extensive help to move and reposition in the bed. Will need two-person assistance to change position or scoot up in bed with an initiation date of 10/10/23. R2's care plan also documented R2 is at risk for falls related to confusion, gait/balance problems, incontinence, limited mobility, medication use, and	S9999		

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S9999	Continued from page 2 unaware of safety needs. This care plan documented R2 is diagnosed with terminal condition and has chosen Hospice services. R2's progress note, dated 7/16/25 at 1:47 PM, documented CNA (Certified Nurse Assistant) was performing AM care in the resident's bed. The resident sustained a ground level fall from bed. Laceration noted left side of lateral forehead and bruising noted to left frontal forehead. Scraped area noted to left knee. Bruising noted to left eye. R2's fall report, dated 7/16/25 at 7:45 AM, documented CNA was performing am care in the resident's bed. The resident sustained a ground level fall from bed. Laceration noted left side of lateral forehead and bruising noted to the left frontal forehead. Bruising noted to left eye. Resident unable to give description. CNA educated on resident requiring (2) staff to perform ADL (activities of daily living) care r/t (related to) resident being dependent on staff. Injuries observed at time of incident: hematoma to face, laceration to top of scalp and left knee. IDT (Interdisciplinary Team) discussing fall on 7/16/25. RCA (root cause analysis) resident sustained a ground level fall from bed during am care. Attempted to interview resident following the incident, resident was unable to provide statement of events due to cognition secondary to dementia. Per interview with resident's roommate, the CNA was performing care and providing incontinent care, the resident was positioned side lying, the CNA reached for a cleaning wipe, the resident moved slightly and rolled off of the side of the bed landing on the ground. The CNA yelled for assistance from the room. The nurse and ADON (Assistant Director of Nursing) arrived. The resident was laying on the left side of the bed. A small laceration was noted to the left side of the resident's head, in addition to a developing hematoma to the left forehead. The resident was triaged with first aid at bedside and hospice provider call for notification and instruction. Neuro assessment noted to be at baseline with no deviation noted. Hospice nurse arrived at facility and instructed the resident did not require higher level of care at this time and instructed facility to continue to monitor. (Cognition score) is 99. Resident has diagnosis of Alzheimer's. It continues, Resident requires max assist with ADLS, and requires mechanical lift for transfers. Intervention: Education to nursing staff related to requiring 2 staff assist for bed mobility. R2's progress note, dated 7/17/25 at 5:16 AM documented peri orbital area of left eye light purple in color. Head remains bandaged in circular fashion with gauze,	S9999		

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S9999	Continued from page 3 which is clean, dry, and intact. Resident does not complain of pain. On 7/24/25 at 9:35 AM surveyor observed R2 laying on a low bed, resident was non-verbal during this observation. R2 had 2 wound closure strips applied to her left forehead near her hairline, a purple raised hematoma above her left eye, purple bruises below her left eye, yellow bruises covering the left side of her face, purple and yellow bruises behind her left ear, and yellow bruising covering the left side of her neck. On 7/24/25 at 12:20 PM surveyor observed V11, Restorative CNA, and V8, CNA, perform incontinent care on R2. R2's bed has grab bars on each side. Surveyor asked V11 if R2 has the ability to reach for and hold on to the grab bars. V11 stated "sometimes we do hand over hand with her." V11 then asked R2 to reach for the grab bar during turning and repositioning, and R2 was unable to follow commands. V11 then placed her hand over R2's hand and guided it onto the grab bar as she was turned onto her left side. R2 was only able to hold on to the grab bar for approximately 10 seconds without assistance. V8 stated "she should definitely be a 2 person assist." V11 stated generally when a resident requires a (mechanical) lift, then they are supposed to have 2 staff for turning and repositioning. On 7/24/25 at 12:46 PM V9 CNA stated she was by herself when she was cleaning and turning R2 on 7/16/25. V9 stated she was never told there had to be 2 CNAS to turn R2. V9 stated she raised R2's bed to her waist level, turned R2 towards the window, turned back to grab the wipes that were on the other side of the bed, felt R2 jerk, and put her leg against the bed to soften R2's fall. On 7/29/25 at 8:48 AM V2, DON, stated she expects the staff to follow the care plan for each resident's bed mobility needs. The facility's Repositioning policy, dated 5/2013, documented the purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning to promote comfort for all bed or chair bound resident and to prevent skin breakdown, promote circulation and provide pressure relief for residents. Preparation: 1. Review the resident's care plan to evaluate for any special needs of the resident. 2. Assemble the equipment and supplies as needed. It continues, repositioning the resident in bed: 1. Check the care plan, assignment sheet or the communication system to determine the resident's	S9999		

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S9999	Continued from page 4 specific positioning needs including special equipment, resident level of participation and the number of staff required to complete the procedure. "B"	S9999		