STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058420	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA BELLA OF EDWARDSVILLE	**6277 CENTER GROVE ROAD , EDWARDSVILLE, Illinois, 62025**

(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) COMPLETION DATE
S0000	Initial Comments Complaint Investigation: 25410411/2650833 25410564/2655225	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 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. Section 300.1210b) 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		

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

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S9999	Continued from page 1 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. This requirement is NOT met as evidenced by: Based on interview and record review, the facility failed to assess and implement appropriate fall intervention for 1 of 3 (R3) residents reviewed for falls in a sample list of 28. This failure resulted in R3 experiencing an unwitnessed fall, sustaining a laceration to his forehead requiring 8 sutures by local hospital. Findings Include: R3's Care Plan, dated 10/22/2025, documents that R3 at risk for falls. The resident has impaired cognition and impaired safety awareness. The resident has balance or walking impairments. The resident has a history of falls., The resident has FUNCTIONAL IMPAIRMENTS OF THE LOWER EXTREMITIES which causes safety issues with transfers and/or walking. Interventions anticipate and meet resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Fall RISK evaluation. Frequent monitoring of resident to ensure safe positioning and needs are met. Keep bed in lowest position acceptable by the resident when the resident is in bed. Turn and reposition. Visual and or verbal reminders to use call light. Family does not want resident to sit up for more than 30 minutes at a time. Discussed with family importance of sitting up for longer intervals to improve resident's strength. R3's Minimum Data Set, dated 10/20/2025, documents that R3 is severely cognitively impaired and dependent on staff for mobility. R3's Fall Assessment, dated 10/15/2025, documents that R3 is high risk for falls. R3's Admission Assessment, dated 10/16/2025, documents that R3's has unsteady gait requiring supervision, impaired balance, and has weakness. R3's Progress Note, dated 10/21/2025 at 4:47 PM,	S9999		

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S9999	Continued from page 2 documents that Nursing staff request this NP evaluate the patient after a ground-level fall with injury. Nursing staff report patient was sitting in his wheelchair waiting the CNA to bring him to the shower. Staff report he was left alone no longer than 4 min. Patient stood up and attempted to walk and lost his balance and his head on the doorknob. He sustained a laceration to his forehead and a puncture wound to his upper lip just beneath his nose. Pressure was applied to his forehead laceration and bleeding had stopped prior to this NP's arrival at bedside. R3's Fall Report, dated 10/21/2025 at 1:15 PM, documents that Incident Description: Nursing Description: This nurse heard a boom and walked down hallway to find resident crawling on floor towards door. Resident Description: Resident Unable to give Description. Was this incident witnessed: N (no). Mental status: oriented to person and situation. Injury type/location: laceration/Face. Notes: resident noted to have a laceration in the middle of his forehead. Predisposing Physiological Factors: Confused and Impaired Memory. Predisposing Situation Factor: Ambulating without assist. Other Info: R3 was in bed after lunch, family requested that he be returned to bed following meal. Family left shortly before resident was returned to bed. Nurse heard noise in room -when she entered room, resident was seen crawling on the floor next to his bed. Resident had sustained a laceration to the middle of his forehead. On 10/23/2025 at 2:28 PM V6, R3's daughter, stated that she and her family visited R3 several days during his stay at the facility. V6 stated that on the day of his fall R3 was up in his wheelchair in the dining room. V6 stated that they were happy about this because R3 had been in the bed at the hospital for 5 weeks. V6 stated that they noticed that R3 was agitated, moving, yelling, and felt maybe the environment was overstimulating for R3. V6 stated that they asked if he could lay down after his meal and was told that this was possible. V6 stated that the family left. V6 stated that shortly after she received a call that R3 fell out of the bed and fell to the floor. V6 stated that she was informed that R3 was crawling on the floor with blood coming from head. V6 stated that she was informed that R3 would be sent to hospital due to having a cut on his head. V6 stated that she was informed that they knew R3 wouldn't stay in the bed and that is why they took his wheelchair out of the room. On 10/27/2025 at 12:50 PM V9, Licensed Practical Nurse, stated that she was R3 nurse on the day of his fall. V9 stated that the family was visiting and requested that	S9999		

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S9999	Continued from page 3 R3 lay down after his meal. V9 stated that R3's family left and R3 stayed in the dining area until he started throwing cups and things. V9 stated that R3 was at that time removed from the dining area. V9 stated that she and V18, Certified Nurses' Assistant, assisted R3 into the bed. V9 stated that R3 was restless, not wanting to stay in the bed and not wanting to be in the chair. V9 stated V18 said that R3 needed a sitter. V9 stated that when admitted they didn't say he needed one. V9 stated that she informed V18 that she would have to talk with management. V9 stated that she informed V18 to go and take care of her other residents. V9 stated that she stayed and tried to calm R3 and keep him still and not trying to get out of the bed. V9 stated that she thought she had calmed and left the room. V9 stated that she made it to the nurses' station and heard a noise. V9 stated that she headed down the hall and saw R3 crawling on the floor with blood coming from head. On 10/28/2025 at 9:52 AM V15, CNA, took care of R3 the day before the fall. V15 stated that R3 was antsy and would move all over the bed. V15 stated that you had to check on R3 every 15 to 30 minutes because he would be all over the place. V15 stated that she never saw R3 stand up to transfer himself. V15 stated that she had came in the room and R3 was in a different position than she left him in. On10/29/2025 at 9:30 AM V9 stated that R3 would roll around in his bed. V9 stated that he would strip clothing and remove his gown and incontinent brief. V9 stated that R3 would pull at his catheter. V9 stated that he would roll around in the bed. V9 stated that she did not see him trying to get out of bed, but he did lay close to the edge with his feet hanging out at times. V9 stated on the day of the fall R3 had gotten up in his wheelchair. V9 stated that R3 didn't want to stay in the chair or in the bed. R3's family came to visit. V9 stated that R3 was throwing dishes and was brought to his room. V9 stated that R3 was assisted to bed. V9 stated that V18 took the wheelchair out of the room to keep R3 from trying to transfer himself. V9 stated that she can't make the decision for a 1 on 1. V9 stated that she must notify and wait for management before a 1 on 1 can be put in place. On 10/29/2025 at 10:56 AM V18, CNA, stated that she was assigned to R3 on the day of his fall. V18 stated that R3 was restless, trying to stand up, get out of bed, and once in the chair he would try to get out of the chair. V18 stated that R3 was making sudden abrupt movements. V18 stated that she knew R3 wasn't safe and stayed with him to keep R3 safe. V18 stated that she stayed with R3 until restorative came and got him up.	S9999		

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S9999	Continued from page 4 V18 stated that R3 was taken to the dining area next to the nurses' station so he could be monitored. V18 stated that shortly after getting to the dining room R3's family came in. V18 stated that she was picking up hall trays and V9 brought R3 back to his room and V18 helped transfer R3 to the bed. V18 stated that they laid him down. V18 stated that R3 was making abrupt jerking movements, trying to get up and then trying to sit down repeatedly. V18 stated that he was not safe alone. V18 stated that she left the room once R3 was in the bed and V9 stayed with R3 to keep an eye on him. V18 stated that she knew he was unsteady, and they had removed the wheelchair to keep R3 from trying to transfer self into it. V18 sated that she sat with him earlier. V18 stated that once you lay him down you had to get him up. V18 stated that R3 would not stay in the bed, and he would not stay in the wheelchair. V18 stated that R3 was confused he was in a different time frame. V18 stated that R3 was saying that his car was stranded and that he needed to go get it. V18 stated that they stayed with R3. V18 stated that at no time was R3 left alone. V18 stated that R3 wasn't safe. R3 stated that the 1 on 1 was provided to keep R3 safe from falling and getting hurt. On 10/30/2025 at 8:50 AM V1, Administrator, stated that if a staff observes a situation that puts a resident at risk for fall and or injury the staff are to put interventions in place at that time and notify management. V1 stated that once they meet the intervention may change. V1 stated that she is confident in her charge nurses that they can implement and discontinue interventions. The facility's Fall Prevention policy, dated 8/15/2025, documents that Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines: 2. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. 4. Low/Moderate Risk Protocols: a. Implement universal environmental interventions that decrease the risk of resident falling, including, but not limited to: i. A clear pathway to the bathroom and bedroom doors. ii. Bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed. iii. Call light and frequently used items are within reach. Iv. Adequate lighting. v. Wheelchairs and assistive devices are in good repair. b. Monitor for changes in resident's cognition, gait, ability to rise/sit, and balance. c. Encourage residents to wear	S9999		

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S9999	Continued from page 5 shoes or slippers with non-slip soles when ambulating. d. Ensure eyeglasses, if applicable, are clean and the resident wears them when ambulating. e. Monitor vital signs in accordance with facility policy. f. Complete a fall risk assessment every 90 days. and as indicated when the resident's condition changes. 5. High Risk Protocols: a. The resident will be placed on the facility's Fall Prevention Program. i. Indicate fall risk on care plan. b. Implement interventions from Low/Moderate Risk Protocols. c. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. d. Provide additional interventions as directed by the resident's assessment, including but not limited to: I. Assistive devices ii. Increased frequency of rounds iii. Sitter, if indicated iv. Medication regimen review v. Lowbed vi. Alternate call system access VII. Scheduled ambulation or toileting assistance v111. Family/caregiver or resident education IX. Therapy services referral (B)	S9999		