

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  145518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/04/2026
NAME OF PROVIDER OR SUPPLIER  LA Bella of Mascoutah		STREET ADDRESS, CITY, STATE, ZIP CODE  201 South 10th Street Mascoutah, IL 62258	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to develop a comprehensive care plan in 3 of 4 residents (R3, R4, R12), reviewed for development of the comprehensive care plan in the sample of 12. Findings Include: Findings include:</p> <p>1. On 2/26/26 at 10:35 AM, R3 was observed in her room in a reclining wheelchair, with the television on. Contractures were observed to the left hand with the fingers completely contracted to the palm of the left hand. There were not any splints/washcloths in place to aid in contracture management.</p> <p>R3's Face Sheet, undated, documents R3 has the following diagnoses: Intracerebral Hemorrhage, Hyperosmolality, Hyponatremia, Plasma Protein Metabolism Disorder, Unspecified Skin Changes, Pulmonary Hypertension, Age Related Debility, Urinary Retention, Protein Calorie Malnutrition, HTN (Hypertension), COPD (Chronic Obstructive Pulmonary Disease), Anorexia, and Pain.</p> <p>R3's MDS (Minimum Data Set), dated 1/1/26, documents R3 has severe cognitive impairment, has impairment in ROM (Range of Motion) in one upper and one lower extremity, is dependent with ADLs (Activities of Daily Living), and is not receiving any ROM programs.</p> <p>R3's Activity Assessment, dated 4/4/25, documents R3 enjoys listening to music, sitting outside, watching TV and movies, prefers to stay in room, and prefers activity programs in small groups or in room.</p> <p>R3's Care Plan, dated 9/30/24, failed to document a ROM/Contracture Management or Activities Care Plan.</p> <p>2. R4's EMR (Electronic Medical Records) undated documents that the resident was admitted to the facility on [DATE].</p> <p>R4's EMR dated 9/3/25 documents a diagnosis of legal blindness, as defined in USA.</p> <p>R4's EMR dated 9/3/25 documents a diagnosis of anxiety disorder, unspecified.</p> <p>R4's EMR dated 10/3/25 documents a diagnosis of other psychotic disorders not due to a substance or known physiological condition.</p> <p>R4's MDS dated [DATE] documents a BIMS score of 14 out of 15. The MDS documents that the resident requires setup or clean-up assistance for roll left and right, sit to lying, lying to sitting on side of bed, and sit to stand. The MDS documents that the resident requires supervision or touching (continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>assistance for chair/bed to chair transfer and toilet transfer.</p> <p>R4's Care plan dated 10/24/25 documents I prefer (Specify: to participate, little participation or no participation) in activity involvement.</p> <p>Care Plan is not done.</p> <p>R4's Activity Assessment (Quarterly or Annually) dated 12/3/25 documents Unedited the form is blank.</p> <p>3. R12's EMR undated documents that the resident was admitted to the facility on [DATE].</p> <p>R12's EMR dated 7/13/25 documents a diagnosis of paralytic syndrome, unspecified.</p> <p>R12's EMR dated 10/20/25 documents a diagnosis of acute respiratory failure with hypoxia.</p> <p>R12's MDS dated [DATE] documents a BIMS score of 11 out of 15. The MDS documents that the resident is dependent for roll left and right, sit to lying, lying to sitting on side of bed, and tub/shower transfer.</p> <p>R12's Activities Assessment (Quarterly or Annually) dated 8/29/25 documents Unedited. Assessment is not done.</p> <p>R12 did not have a care plan for the resident's preference for activities.</p> <p>On 2/27/26 at 12:17 PM, V8, Activity Director/Social Service Designee stated that activity assessment and social service assessments should be done on admission and quarterly. She stated that care plans for activity and social service should be updated every 3 months.</p> <p>On 2/27/26 at 12:23 PM, V20, MDS/Care Plan Coordinator stated that care plans should be updated quarterly.</p> <p>On 3/3/26 at 11:38 AM, V1, Administrator, stated she is aware the care plans need to be updated and they are currently in the process of doing this.</p> <p>The Care Plan Policy, with a revision date of 11/6/19, documents the facility's care planning/interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. The care plan is based on the resident's comprehensive assessment.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, interview, and record review, the facility failed to provide positioning assistance to 2 of 3 residents (R3, R11), when reviewed for ADL (Activities of Daily Living) care provided to dependent residents in the sample of 12. Findings Include: 1. On 2/26/26 at 8:40 AM, R3 was observed in the dining room, up in her reclining wheelchair being assisted with the breakfast meal. On 2/26/26 at 10:35 AM, R3 was observed in her room in her reclining wheelchair. On 2/26/26 from 8:40 AM to 1:00 PM, R3 was observed in 15-30-minute increments, R3 was not repositioned during that time. On 2/26/26 at 1:30 PM, R3 was observed being assisted to bed by staff. On 2/26/26 at 1:30 PM, V4, CNA (Certified Nursing Assistant) stated she laid R3 down after breakfast, incontinent care was provided and was repositioned. V4 stated she was unsure of the exact time and did not lay R3 down or reposition her again until 1:30 PM. R3's Face Sheet, undated, documents R3 has the following diagnoses: Intracerebral Hemorrhage, Hyperosmolality, Hyponatremia, Plasma Protein Metabolism Disorder, Unspecified Skin Changes, Pulmonary Hypertension, Age Related Debility, Urinary Retention, Protein Calorie Malnutrition, HTN (Hypertension), COPD (Chronic Obstructive Pulmonary Disease), Anorexia, and Pain. R3's MDS (Minimum Data Set), dated 1/1/26, documents R3 is dependent with ADLs. R3's Care Plan, dated 9/30/24, documents R3 has an ADL self-care performance deficit and requires staff assistance with care needs. 2. On 2/26/26 at 8:15 AM, R11 was observed in her reclining wheelchair in the dining room. On 2/26/26, from 8:15 AM to 12:45 PM, R11 observed in 15-30-minute increments and was in the dining room in her wheelchair and had not been repositioned. On 2/26/26 at 1:50 PM, R11 was observed being assisted to bed with staff. On 2/26/26 at 2:00 PM, V5, CNA, stated she laid R11 down after breakfast, unsure of time, provided incontinent care and got her back up in her reclining wheelchair. On 3/3/26 at 11:38 AM, V1, Administrator, stated the residents that are unable to reposition themselves should be assisted by staff every two hours. The Activities of Daily Living Policy, with a revision date of 3/17/25, documents residents will be provided with care, treatment and services as appropriate to maintain or improve their quality of life. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with their plan of care, including appropriate support and assistance with (in part): mobility.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to provide a comprehensive assessment and preference for 3 of 3 (R4, R5, R12) residents investigated for activities in a sample of 12.1. R4's EMR (Electronic Medical Records) undated documents that the resident was admitted to the facility on [DATE].R4's EMR dated 9/3/25 documents a diagnosis of legal blindness, as defined in USA.R4's EMR dated 9/3/25 documents a diagnosis of anxiety disorder, unspecified.R4's EMR dated 10/3/25 documents a diagnosis of other psychotic disorders not due to a substance or known physiological condition.R4's MDS dated [DATE] documents a BIMS score of 14 out of 15. The MDS documents that the resident requires setup or clean-up assistance for roll left and right, sit to lying, lying to sitting on side of bed, and sit to stand. The MDS documents that the resident requires supervision or touching assistance for chair/bed to chair transfer and toilet transfer.R4's Care plan dated 10/24/25 documents, I prefer (Specify: to participate, little participation or no participation) in activity involvement.Care Plan is not done.R4's Activity Assessment (Quarterly or Annually) dated 12/3/25 documents Unedited the form is blank.2. R5's EMR undated documents the resident was admitted to the facility on [DATE].R5's EMR dated 7/24/20 documents a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.R5's EMR dated 10/18/21 documents a diagnosis of morbid (severe) obesity due to excess calories.R5's EMR dated 7/29/20 documents a diagnosis of major depressive disorder, single episode, unspecified.R5's MDS dated [DATE] documents a BIMS score of 15 out of 15. The MDS documents that the resident that the resident requires supervision or touching for roll left and right, sit to lying, lying to sitting on side of bed, and sit to stand. The MDS documents that the resident partial/moderate assistance for chair/bed to chair transfer and toilet transfer.R5's Activities Assessment (Quarterly or Annually) dated 7/26/25 documents Unedited the form is blank.3. R12's EMR undated documents that the resident was admitted to the facility on [DATE].R12's EMR dated 7/13/25 documents a diagnosis of paralytic syndrome, unspecified.R12's EMR dated 10/20/25 documents a diagnosis of acute respiratory failure with hypoxia.R12's MDS dated [DATE] documents a BIMS score of 11 out of 15. The MDS documents that the resident is dependent for roll left and right, sit to lying, lying to sitting on side of bed, and tub/shower transfer.R12's Activities Assessment (Quarterly or Annually) dated 8/29/25 documents Unedited. Assessment is not done.During this investigation, no observations of R4 and R12 engaging in any activities nor did any activity staff engage with R4 and R12 for 1 on 1 activities. R5 was observed playing bingo one day.On 2/26/26 at 8:20 AM, R4 stated that there are no activities for him except bingo and he only plays bingo to get snacks.On 2/27/26 at 12:17 PM, V8, Activity Director/Social Service Designee stated that activity assessment and social service assessments should be done on admission and quarterly. She stated that care plans for activity and social service should be updated every 3 months.On 2/27/26 at 12:23 PM, V20, MDS/Care Plan Coordinator stated that care plans should be updated quarterly.Facility's Activity Programs policy and procedure dated 11/5/19 documents An ongoing program of activities is designed to meet the needs of each resident.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to implement safety measures to prevent falls in 1 of 5 residents (R11) when reviewed for freedom of accidents in the sample of 12. Findings Include: On 2/27/26 at 9:48 AM, R11 was observed in the dining room in her wheelchair with a clear plastic lap tray in place. The tray is attached to the wheelchair with Velcro straps going from the tray to the wheelchair arm rests. The tray is easily moved and slides up/down very easily. R11's Progress Note, dated 12/19/25 at 10:07 PM: 9:25 PM, documents the following: Resident observed lying on her back/right side in dining room next to her wheelchair. No apparent physical injury; AROM (Active Range of Motion) and PROM (Passive Range of Motion) WNL (Within Normal Limits) for resident. Neuro checks initiated and WNL for resident. VSS (Vital Signs Stable) 120/78, 63, 16, 97.4, 99% RA (Room Air). 9:35 PM, DON (Director of Nurses), Administrator, POA (Power of Attorney), and MD (Medical Doctor) notified. POA would like resident to be sent to the local hospital. 9:50 AM, Transferred from floor to stretcher by 2 EMT's (Emergency Medical Technician), transported via ambulance. R11's Progress Note, dated 12/20/25 at 5:30 AM, documents the following: The nurse at the local hospital called to give report said CT of the head was normal, also did UA (Urinalysis) with reflex to C&amp;S (Culture &amp; Sensitivity). UA was positive sent for C&amp;S, Rocephin 1gm (gram) given at hospital, script for Vantin (Cefpodoxime) sent to pharmacy. Resident returned to facility at 5:15AM, resident transferred from stretcher to bed, no signs or symptoms of pain or discomfort at this time, call light within reach. R11's Face Sheet, undated, documents R11 has the following diagnoses: CP (Cerebral Palsy), Seizures, Dependence on Wheelchair, Disorders of the Muscle, and Intellectual Disability. R11's MDS (Minimum Data Set), dated 12/12/25, documents R11 has severe cognitive impairment and is dependent with ADLs (Activities of Daily Living). R11's Care Plan, dated 3/31/25, documents R11 has the potential for falls due to confusion, deconditioning, gait/balance problems, incontinence, poor communication/comprehension, and is unaware of safety needs with an intervention for a lap tray to be used while R11 is up in her chair to prevent falls and ensure resident safety. There were no new interventions implemented for R11's fall on 12/19/26. The Facility Repair Requisition, dated 12/19/26, included in R11's investigation of the fall, documents the following: Specialized chair check and problems apparent. Placed apparent. Placed arm back on chair. Transfer belt to assure resident's safety. There was no name on the requisition. On 2/27/26 at 9:17 AM, V9, CNA (Certified Nursing Assistant) stated she was working on 12/19/26 when R11 fell. V9 stated she was on break and came back and found R11 lying on the floor in the dining room. V9 stated R11 did have her lap tray on but it wasn't secure and the family and facility knew that. V9 stated when R11 moves around in her wheelchair, the tray loosens, lifts and slides off and R11 will slide out of her wheelchair. V9 stated she did not witness R11 fall but is sure that is what caused her to fall. On 3/3/26 at 11:38 AM, V1, Administrator, stated, she understands R11's tray is easily moved/loose and will have maintenance address this. The Fall Reduction Policy, with a revision date of 10/30/24, documents the purpose of the policy is to provide an environment that remains as free of accident hazards as possible and to identify residents who are at risk for falling and to develop appropriate interventions to provide supervision and assistive devices to prevent or minimize fall related injuries.</p>		