STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145651	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Bella of Alton	3490 Humbert Road Alton, IL 62002

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 34964 Based on interview and record review, the facility failed to follow through on a recommendation for a medication change for 1 of 11 residents (R2) reviewed for medications in the sample of 11. Findings include: On 4/23/24 at 2:00PM, V15, R2's Guardian, stated, in January, after R2 was seen by the surgeon, the surgeon called her and told her R2 is cancer free and he will be starting back on his Levothyroxine 137 micrograms, (mcg). V15 stated, that never happened and then some Doctor with the facility, started him on a different dose and his Endocrinologist is upset. V15 stated, she doesn't want anyone changing any of R2's medications without consulting V17, his Endocrinologist. R2's Face Sheet, printed on 4/18/24, documents, his diagnoses to include Vascular Dementia, Unspecified Cirrhosis of Liver, Cerebral Infarction, Hypertension and Postprocedural Hypothyroidism. R2's Order Audit Report dated 4/18/24 documents, an order dated 2/01/24 by V7, Physician Assistant, for R2 to start taking Levothyroxine 112 mcg one time a day for hypothyroidism. Per the Order Audit Summary this order was discontinued on 4/11/24 and R2 was ordered Levothyroxine 137 mcg one time a day for hypothyroidism by the facility's Medical Director. R2's Progress Note from his appointment with Radiation Oncology dated 1/02/24 by V16, Registered Nurse, (RN) at the Oncology clinic documents, he spoke to V20, Licensed Practical Nurse, (LPN), from the facility, regarding setting up an appointment for R2 to receive a radioactive iodine treatment on 1/12/24. Per this progress note, V16 informed V20 that R2 will need to have labs drawn at the facility on 1/09/24 before the treatment. The progress note, also documented, R2 will have a consultation appointment on 1/12/24 on the same day as the treatment and R2 will start on Levothyroxine on 1/13/24. At the end of the progress note, it documented, that V20, on behalf of the patient (R2) verbalized understanding of above instructions and instructions were faxed to the facility's fax number. R2's Progress note dated 1/12/24 at 3:27PM, from V16 at the Radiation Oncology clinic documents, Called post radioiodine treatment report to (V20) at facility. (V20) verbalized understanding of post treatment instructions and was faxed a copy of the same to (facility's fax #). (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Encounter Information dated 1/12/24 at 3:18PM, and signed by V16, RN documents, Patient here for consult and radioactive iodine, (RAI), treatment. Accompanied by niece (V15). Patient educated and provided printed education materials on 48-hour isolation precautions and possible side effects of RAI treatment. Patient will start daily oral levothyroxine 137 mcg tomorrow and was educated and provided with printed educational materials on levothyroxine. Patient verbalized understanding to have post treatment labs drawn in 6-weeks and was given a paper lab requisition. Patient will return for post therapy scan on 1/16/24 and given instructions on location and time. Patient stated, their Endocrinologist is (V17). Patient verbalized understanding of all info and questions answered. R2's Progress Note dated, 4/09/24 from the Endocrinology Clinic, co-signed by V17, R2's Endocrinologist documents, Thyroid Clinic Lab Follow UP: Spoke to patient's niece, (V15), at (her phone number). TSH, (Thyroid Stimulating Hormone), not suppressed. Recommend increasing dose from Levothyroxine 112 mcg daily, to 137 mcg daily which is what he had been discharged on . R2's Medication Administration Record, dated, 2/01/24 - 2/29/24 documents, his first dose of Levothyroxine 112 mcg daily was administered on 2/02/24. This MAR and the MARs dated 3/01/24-3/31/24 and 4/01/24 to 4/30/24 document, R2 continued to receive Levothyroxine 112 mcg, until 4/11/24 when the order was changed to Levothyroxine 137 mcg daily. R2's MAR dated 1/01/24-1/31/24 did not document any Levothyroxine was given as ordered on 1/12/24. On 4/23/24 at 3:44PM, V18, RN identified herself as V17's, R2's Endocrinologist's, Nurse. She stated, R2 was seen in clinic by V17 on 4/09/24 and was given an order for Levothyroxine to be increased to 137 mcg as he had been only receiving 112 mcg. She stated, V17 had given the prescription for R2 to receive Levothyroxine 137 mcg on 1/12/24, but she did not know who had changed the order to 112 mcg. She stated, R2 received the order for Levothyroxine 137 mcg on 1/12/24, when he was seen in the Radiation Oncology Clinic. She stated, the prescription had been sent to (facility's pharmacy) at that time to be filled as this was his designated Pharmacy. V18 stated, R2 not receiving 137 mcg, starting on January 12, 2024, as ordered, and not having received any thyroid replacement therapy, until 2/02/24 would have had the side effects of R2 feeling more tired and not having much energy. She stated, when V17 had R2's labs drawn on 4/09/24, his thyroid levels were improved, but V17 likes to keep them a little lower, because of R2's history of thyroid cancer. V18 stated, R2's increased dose of Levothyroxine, should lower his levels even more, which is the desired outcome V18 wants to achieve. On 4/24/24 at 9:30AM, V20, LPN stated, she does remember having a conversation with R2's Radiation Oncology staff when they were making plans for his iodine treatment, because they had to make plans for him to be on isolation for a couple of days after his treatment. She stated, this meant he would be moved to another hall for a short time. V20 stated, she was not R2's nurse on the day he got his treatment, but stated, if he came back without orders, the nurse taking care of him should have called the Radiation Oncology Office and requested paperwork for after-treatment orders. V20 stated, she works on different halls day to day, but she recalls R2's Doctors were usually good about sending paperwork back with R2 after his appointments. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 9:45AM, V8, LPN stated, she was R2's nurse when he was sent out for his iodine radiation treatment on 1/12/24, but he would have come back to a room on a different hall, due to needing to be isolated. She stated, most times R2's niece, now guardian, would go to appointments with him and she would keep the paperwork and the facility staff, would have to call her and ask about any changes or new orders. V8 stated, if the nurse who was taking care of R2, after he returned from his treatment on 1/12/24, did not receive any orders when he returned, that nurse should have reached out to the Oncology Office and requested his discharge orders, because this was R2's first time receiving that treatment and he had just had his thyroid removed, so they really should have made sure they knew just what was going on with him and if there were any changes in his orders. V8 stated, he returned to her hall after his few days of isolation were completed, but she did not see any order for him to be started on Levothyroxine and could not find anything in his chart regarding his 1/12/24, visit to the Radiation Oncology Clinic or what treatment he received that day. On 4/24/24 at 9:06 AM V1, Administrator, stated, when a resident goes to a medical appointment outside the facility, she would expect the nurse taking care of that resident to follow up with that resident, (if they are alert and oriented) or their family and ask if there were any changes or new orders as an outcome of the appointment. V1 stated, if there is no documentation provided after the outside appointment, she would expect that resident's nurse to call the medical office where the resident was seen and request documentation of any new orders or changes, or follow-up appointments, if needed. V1 stated, she had to get on Epic, a computer program with resident's MD, (Medical Doctor) and hospital reports to pull info on R2's visits on 1/02/24 and 1/12/24, but could not find any documentation, of these visit reports in R2's EMR at time of those appointments. V1 stated, she could not find progress notes or orders from his outpatient visits on 1/02 or 1/12 in R2's electronic medical record, (EMR). On 4/24/24 at 2:12 PM V1, Administrator, stated, the facility does not have a policy specific to following up and obtaining information after a residents outside medical appointments.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 34964 Based on observation, interview and record review, the facility failed to Administer Medications as ordered by the Physician for 1 of 11 residents (R11) reviewed for medications in the sample of 11. Findings include: On 4/24/24 at 8:25AM, a medication pass was observed with V19, Licensed Practical Nurse, (LPN), when she administered medications to R11. R11's Order Summary Report dated 4/24/24, documents, the order: 1/02/24: Folic Acid Oral Tablet 1 milligram, (mg), Give 3 tablets by mouth one time a day for supplement. During the observed medication pass, V19 only administered one Folic Acid 1 mg tablet, instead of the 3 tablets that were ordered. R11's Order Summary Report, also documented, the order: 3/28/24: Lamotrigine Oral Tablet 25 mg Give 2 tablets by mouth in the morning for seizures. During the observed medication pass, V19 only administered one tablet of Lamotrigine 25 mg, instead of the two tablets ordered by the Physician. R11's Order Summary Report, also documented, the order dated 1/05/24: Sertraline HCl Tablet 100 mg, Give 2 tablets by mouth one time a day for depression, related to Major Depressive Disorder, Recurrent, in Partial Remission. During the observed medication pass, V19 only administered 1 tablet of Sertraline HCl 100 mg to R11, instead of 2 tablets, as ordered by the Physician. R11's Order Summary Report, documents, the order dated 1/02/24: Symbicort Inhalation Aerosol 80-4.5 mcg, (micrograms),/ACT, (Asthma Control Test), (Budesonide-Formoterol Fumarate Dihydrate), 2 puffs, inhale orally, two times a day for SOB, (Shortness of Breath). V19 did not administer or offer, R11's a Symbicort inhaler to her during the observed medication pass. After dispensing R11's medications into a medication cup, V19 counted, the pills in the cup and stated, There are 11 pills in the cup. If all medications were pulled up as ordered, omitting R11's Oxybutynin, which V19 had to get out of the convenience dispenser, there should have been 15 pills, in the cup. After administering the medications, she had placed in R11's medication cup to R11, V19 stated, to R11, I'll see you around lunch time. and exited the room. On 4/24/24 at 11:00AM, V2, Director of Nursing, (DON), provided progress notes dated, 4/24/24 at 9:47AM and 10:06AM documenting, 2 Folic Acid, Symbicort and one Sertraline were administered late per staff Physician approval. There was no documentation, that V11 administered another Lamotrigine 25 mg tablet to make up the correct dose of that medication. V2 stated, (R11) has now gotten all the medication she had ordered this morning. I think (V19) just got nervous because she was being watched during her medication pass, but that's not an excuse to give that many wrong doses during one med pass. On 4/24/24 at 4:00 PM V1, Administrator, stated, V19 was very stressed and anxious during the medication pass and feels bad, that she missed some of (R11's) medications. V1 stated, she and V2, educated V19 regarding double checking her medications before administering them. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy, Administering Medications, revised April 2019, documents, Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 7. Medications are administered within one, (1), hour of their prescribed time, unless otherwise specified, (for example, before and after meal orders). 10. The individual administering the medication checks the label three, (3), times to verify the right resident, right medication, right dosage, right time and right method, (route), of administration before giving the medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49578 Based on observation, record review, and interview the facility failed to provide Therapeutic Diets as ordered by the Physician for two of three residents (R2 and R4) reviewed for Therapeutic Diets in a sample of 11. Findings Include: 1. On 4/23/2024 at 12:00PM, R4 received his lunch tray in his room. Observed his lunch to be a single serving of pasta and meat, (protein), and double portion of salad. R4's meal ticket documented, no specific diet order. On 4/18/2024 at 2:55PM, R4 face sheet revealed a diagnosis of sepsis, malignant neoplasm of rectum, history of antineoplastic chemotherapy; severe, protein calorie malnutrition, colostomy, human immunodeficiency virus disease, gastroesophageal reflux disease without esophagitis, iron deficiency anemia, hypokalemia, osteomyelitis of vertebrae, sacral and sacrococcygeal region, encounter for surgical aftercare following surgery on the digestive system. R4's Physician Order, dated, 4/16/24, documents, the order: Regular diet, Regular texture, Regular liquids consistency, double protein at lunch, diet order active 4/16/2024. R4's Physician Order dated, 4/23/2024, documents: House Nutritional Supplement one time a day, 120 milliliters, (ml), active 4/23/2024. On 4/23/2024 at12:30PM V4, Dietary Manager stated, she did not know what R4's Diet order is and went to the kitchen to check. She returned and stated, R4 is on a Regular Diet. V4 stated, she was not aware of R4's, Physician Order, on 4/16/24 and will start his double portions on 4/24/24, 8 days after R4 received the order for Double Portions at lunch. 34964 2. R2's Face Sheet printed 4/18/24, documents, his diagnoses to include Rhabdomyolysis, Vascular Dementia, and Cognitive Communication Deficit. It documents, at the time he was admitted to the facility, his diagnoses included Morbid, (Severe), Obesity due to Excess Calories. R2's Minimum Data Set, (MDS), dated [DATE], (Annual): documents, he is severely cognitively impaired. R2's Physician Order dated, 9/18/23 documents, his diet order as: Regular Diet, Regular Texture, Regular Liquids consistency; super cereal at breakfast; ice cream at lunch and dinner, double portions at all meals for diet. R2's Care Plan, undated, documents, the Focus: Resident has specific nutritional needs. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Goal: Resident will not experience an unplanned weight loss of 5% or more in a month or a loss of 10% in 180 days. Resident will maintain adequate nutrition levels. Interventions for this care plan include: Provide diet and serve as ordered; Provide supplements as ordered, RD, (Registered Dietician), to evaluate as needed; Report unplanned/unexpected weight loss to physician and/or RD; Able to feed self after set up. At times, behaviors/lethargy may interfere with PO, (oral), intake-reapproach as able. R2's Registered Dietician, Note dated 1/11/24 documents, R2 was readmitted on [DATE] after acute hospitalization for Thyroid Nodules s/p, (status post), Thyroidectomy, (pathology reports indicates thyroid cancer). Appetite good, (75-100%), of all meals. Despite PO, (oral), intake, weight trended down significantly x 6 months likely related to undiagnosed thyroid cancer. On 4/18/24 at 12:00PM V10, Certified Nursing Assistant, (CNA), delivered R2's lunch tray to him in his room and set it on his over-bed table. There was a double portion of the main course, (pasta dish), on R2's plate along with mixed vegetables and a bread stick. R2 had a soda on his table and there was water and lemonade served with his meal. There was no ice cream on his tray. V10 showed writer R2's meal ticket which documented, double portions and ice cream. V10 stated, ice cream may just be one of his likes. She did not go and get R2 any ice cream but continued to pass trays on the hall. On 4/24/24 at 8:40 AM V9, CNA was picking up breakfast trays from residents' rooms on the 300-Hall. R2's tray was observed. V9 stated, he ate all of his scrambled eggs with cheese and toast. A bowl of plain cream of wheat cereal was observed on R2's finished tray. V9 stated, they did not send him any super cereal today, only regular cream of wheat, and he did not eat it. The cream of wheat was white and did not appear to have any additives of butter or brown sugar added. On 4/23/24 at 11:45 AM V4, Dietary Manager, stated, each resident's diet is individualized whether it is due to a resident's preference or a Physician's Order. She stated, if there is a Physician Order specific to that resident, it will be listed on their diet card as other order and diet should be provided as ordered. She stated, sometimes it depended on availability of some items such as ice cream, whether they received it from the vendor or not. V4 stated, she did not recall any notifications of ice cream not being available from vendor on 4/18/24 and R2 should have received ice cream on his lunch and dinner tray if it was ordered by the Physician. She stated, if ice cream was listed on his meal ticket, but was not on his tray, the staff should have come back and asked for it. On 4/24/24 at 8:56AM, V4 stated, super cereal is either cream of wheat or oatmeal with brown sugar, butter and mild added to it. She stated, the cream of wheat would not have appeared white if brown sugar and butter had been added to make it super cereal, and it would have been runnier, due to milk being added. When informed R2 did not receive super cereal as ordered for breakfast this morning, V4 stated, OK, I'll have to look into it. The facility's undated policy, Therapeutic Diets documents, Therapeutic Diets are prescribed by the attending Physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. 1. Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. Diagnosis alone will not determine whether the resident is prescribed a Therapeutic Diet. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. A Therapeutic Diet must be prescribed by the resident's attending Physician (or non-physician provider). The attending Physician may delegate this task to a registered or Licensed Dietitian as permitted by state law. 2. A 'Therapeutic Diet is considered a diet ordered by a Physician, Practitioner or Dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example: 1. diabetic/calorie-controlled diet. 2. low sodium diet. 3. cardiac diet; and 4. altered consistency diet. R4's Physician Order dated 4/16/24 documents, the order: Regular diet, Regular texture, Regular liquids consistency, double protein at lunch, diet order active 4/16/2024. R4's Physician Order dated 4/23/2024 documents: House Nutritional Supplement one time a day 120 milliliters, (ml), active 4/23/2024. On 4/23/2024 at12:30PM V4, Dietary Manager stated, she did not know what R4's diet order is and went to the kitchen to check. She returned and stated, R4 is on a Regular Diet. V4 stated, she was not aware of R4's Physician Order on 4/16/24 and will start his Double Portions on 4/24/24, 8 days after R4 received the order for Double Portions at lunch.