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	08/22/2024

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

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)
F 0578 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview and record review, the facility failed to update and have appropriate documentation regarding the Code Status/Advanced Directives for 2 of 3 residents (R3, R4) reviewed for Advanced Directives in the sample of 12. Utilizing the reasonable person concept, R3 made his advanced directive choices clear when updating his directive status in [DATE] to Do No Resuscitate (DNR) status. Due to the facility failure to correctly identify his DNR, R3 experienced life saving measures including intubation and extubation prior to expiring. The Findings Include: 1. R3's Face Sheet, undated, documents R3 was originally admitted to the facility on [DATE] and was discharged to the hospital on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Respiratory Failure, Panlobular Emphysema, Type 2 Diabetes Mellitus (DM), Malnutrition, Schizophrenia, Hypertension (HTN), Dependence on Supplemental Oxygen, COVID-19, and Deep Vein Thrombosis (DVT). R3's Care Plan, dated [DATE] documents: ([DATE]) R3 Is a FULL CODE, CPR Order: Attempt CPR. Interventions: [DATE]: Resident is a FULL CODE, Allow opportunity to review and initiate Advanced Directives with the resident and/or appointed health care representative. R3's Minimum Data Set (MDS), dated [DATE], documents R3 had a moderate cognitive impairment and required setup or clean up assistance for most ADLs. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 12:19 PM, V5, Registered Nurse (RN) stated I was the emergency room (ER) Nurse who took care of (R3) when he went to theER on [DATE]. (R3) was very hypoxic upon arrival to the hospital with the Fire Department getting an oxygen saturation of 65%. The Emergency Medical Service (EMS) guys told us that the Nurse at the facility who was taking care of (R3) knew nothing about him and stated she was just a temp there working. No one at the facility was able to tell EMS when (R3) was last seen well, or how long he was like that. The facility gave EMS paperwork that indicated (R3) was a Full Code, so we intubated (R3) in attempts to resuscitate him. The facility did not call (R3's) brother, who was also his POA (V6), to let him know they were sending (R3) to the ER, and when (V6) showed up at the facility to see (R3), he was told that (R3) was taken to the hospital. Then (V6) showed up at the ER and saw (R3) intubated, he told us that (R3) was a Do Not Resuscitate (DNR) and that he did not want to be intubated. He told us they signed the appropriate paperwork back in [DATE] for that, and he provided that paperwork to the facility, and they should have sent that. The ER Physician had to withdraw care and let R3 pass away. On [DATE] at 12:40 PM, V6, R3's Brother/POA, stated I went to the facility to check on (R3) on [DATE]. When I got to the facility, I went to (R3's) room, and he was not there, and his roommate stated that they took (R3) to the hospital. When I asked, it took three different staff members just to tell me which hospital he went to. When I got to the ER, I found out that the hospital had intubated (R3) and they should not have done so because (R3) was a DNR/Do Not Intubate (DNI). The ER Nurse showed me the paperwork from the facility that was sent with (R3) and it did show that (R3) was a Full Code. I signed paperwork in [DATE] with (R3) indicating that (R3) was a DNR and the facility should have had that in his record, but they sent the wrong one. I was not happy because my sister and I had to make the decision to terminate (R3's) care, so they extubated (R3) and let him pass away. On [DATE] at 9:05 AM, V1, Administrator, stated I was aware that (R3) went to the hospital due to respiratory distress and had passed away in the hospital, but I was not aware of any issues. On [DATE] at 9:25 AM, V16, Social Service Director, stated It looks like (R3's) POA paperwork that was given to us in [DATE] was scanned into his medical record by the Business Office Manager and that is weird because she shouldn't be the one doing that. I didn't even know that (R3's) family brought in new paperwork. I think this would fall on this facility's communication. (R3's) POLST should have been updated once we received the new POA paperwork and we should have sent the new POLST and the POA paperwork with (R3) when he went to the hospital. I feel bad because I heard the family had to make that tough decision to let him go like that. On [DATE] at 9:40 AM, V4, VP Clinical Operations, stated I did my own audit of the facility and found the same issues with some residents having an outdated POLST that did not match other documentation in the medical record. I also saw some resident Care Plans that had conflicting Advance Directives and I fixed those. I did see that (R3) had the two conflicting Advance Directives in his Care Plan, but I was not aware of (R4's) because that was back in May. I would expect the MDS Nurse to make appropriate changes to the Care Plan with updated information when necessary. I would also expect the staff to make sure Nursing has the most up to date information available to them. R3's POLST, dated [DATE], documents R3 was a Full Code. R3's POA Paperwork, dated [DATE], documents R3 and his POA signed indicating R3 did not want lifesaving sustaining treatment. (continued on next page)

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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 0578 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R3's Physician Order, dated [DATE], documents Advance Directive: Full Code. R3's Hospital Record - page 2, dated [DATE], documents [AGE] year-old male with a history of COPD, acute respiratory failure with hypoxia, panlobular emphysema, moderate protein calorie malnutrition, type 2 diabetes, hyperlipidemia, hyponatremia, hypoosmolality, electrolyte imbalance, schizophrenia, dysphagia, hypertension, oxygen dependence that was brought in by EMS secondary to altered mental status and hypoxia. Upon arrival, EMS noted, patient last known well was last night approximately 9:00 PM, however has not been seen until 10:00 AM this morning, all of the nurses at the facility where traveler's and did not know this patient. They did note that he is normally up and smoking however. Upon arrival, EMS noted patient was altered, not following commands, satting in the mid 60s, unsure of how long this has been going on, improved to the 90s with a non-rebreather. No family is at the bedside. R3's Hospital Record - page 13, dated [DATE], documents Spoke with the brother (V6) at the bedside, he notes the patient was a DNR and has a very poor quality of life over the last number of days to weeks. He states the signed paperwork is at the facility however the paperwork we initially received has him as a full code. He is going to call his sisters, although he is the POA, to confer and decide the next steps at this time. Brother has opted for extubation and removal of care, comfort measures only. Time of death called, ultrasound confirmed cardiac standstill, brother at the bedside, will page his primary care. R3's Hospital Record - Page 17, documents Patient's brother to bedside. Patient's brother states what facility told EMS was not true and patient has been weaker/not normal since Sunday. Patient's brother also states patient is DNR/DNI, brother is POA. [NAME] (ER Physician) to bedside to discuss POC (plan of care) due to paperwork from facility showing full code. 2. 2. R4's Face Sheet, undated, documents R4 was originally admitted to the facility on [DATE] and was discharged on [DATE] with diagnosis of Metabolic Encephalopathy, Fracture Tibia, Mitral Valve Insufficiency, Adult Failure to Thrive, Malnutrition, Pulmonary Hypertension, Anemia, Hypothyroidism, Cardiomyopathy, Gangrene, HTN, Cellulitis Left Lower Extremity (LLE), Rhabdomyolysis, Peripheral Vascular Disease, Congestive Heart Failure, and Acquired Absence of Right Above Knee Amputation (AKA). R4's Care Plan, dated [DATE], documents ([DATE]) R4 has an Advanced Directives on record. Interventions: Advise resident and/or appointed health care representative to provide copies to the facility of any updated Advanced Directives, Discuss Advanced Directives with the resident and/or appointed health care representative. ([DATE]) R4 is a Full Code. Interventions: Allow opportunity to review and initiate Advanced Directives with the resident and/or appointed health care representative. R4's MDS, dated [DATE], documents R4 had a moderate cognitive impairment and was dependent on staff for all ADLs. R4's POLST, dated [DATE], documents R4 is a Full Code. R4's POA Paperwork, dated [DATE], documents R4 does not want treatments to prolong her life or delay her death, but she does want treatment or care to make her comfortable and to relieve her of pain. (continued on next page)

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F 0578 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Facility's Advanced Directives Policy, dated ,d+[DATE], documents The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. 1. The facility defines the following in accordance with current OBRA definitions and guidelines: a. Advance care planning - a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions. b. Advance Directive - a written instruction, such as a living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is incapacitated (per S489.100). (2) Durable Power of Attorney for Health Care (i.e., Medical Power of Attorney) - a document delegating authority to a legal representative to make health care decisions in case the individual delegating that authority subsequently becomes incapacitated. (3) Do Not Resuscitate (DNR) - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used. 1. If the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. 2. The director of nursing services (DNS) or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the resident's medical record and plan of care. 3. The resident's wishes are communicated to the resident's direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the resident's wishes in care planning meetings. 4. The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive. 7. The interdisciplinary team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the medical record. 8. Changes or revocations of a directive must be submitted in writing to the administrator. The administrator may require new documents if changes are extensive. The interdisciplinary team will be informed of changes and/or revocations so that appropriate changes can be made in the resident medical record and care plan. 9. The nurse supervisor is required to inform emergency medical personnel of a resident's advance directive regarding treatment options and provide such personnel with a copy of the advance directive or POLST when transfer from the facility via ambulance or other means is made.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44967 Based on interview and record review, the facility failed to notify the resident's responsible party prior to a transfer to an acute care facility for evaluation and treatment of a change in condition for 2 of 3 residents (R3, R4)) reviewed for hospitalization in the sample of 12. The Findings Include: 1. R3's Face Sheet, undated, documents R3 was originally admitted to the facility on [DATE] and was discharged to the hospital on 8/16/24 with diagnosis of Chronic Obstructive Pulmonary Disease (COPD), Respiratory Failure, Panlobular Emphysema, Type 2 Diabetes Mellitus (DM), Malnutrition, Schizophrenia, Hypertension (HTN), Dependence on Supplemental Oxygen, COVID-19, and Deep Vein Thrombosis (DVT). R3's Care Plan, dated 7/25/24, documents R3 has a behavior problem related to threatening and cursing staff. R3 refuses labs, and wearing oxygen, R3 is a smoker/tobacco user and refuses to give cigarettes to staff for safe keeping. It continues 8/16/24: R3 is at Risk for rehospitalization and or unsuccessful discharge related to health determinant needs, resident refuses care such as keeping oxygen on and lab draws. It continues 8/16/24: R3 has actual/potential altered respiratory status related to: COPD, Emphysema, Respiratory Failure, history of COVID. R3 refuses oxygen at times. Interventions: Administer medications / inhalers / nebulizers as ordered, monitor for effectiveness, elevate head of bed as needed to facilitate ease of breathing, maintain a clear airway by encouraging resident to clear own secretions with effective coughing. If secretions cannot be cleared, suction as ordered/required to clear secretions, monitor for changes in/development of signs and symptoms of breathing difficulty and report to nurse if noted: Shortness of breath, cough (productive or non-productive), fever, chills, difficulty speaking, bluish skin color, changes in cognition, monitor lab/diagnostics as ordered and report results to physician, monitor skin integrity of ears, nasal area, or facial areas for pressure or friction issues related to nasal cannula or Oxygen (O2) mask, report any noted skin irritation or breakdown, notify nurse for any observed or reported breathing difficulty, excess secretions, or persistent coughing, report changes in respiratory status to physician, administer continuous oxygen as ordered via: O2 at 3 liters per mask (LPM) or nasal cannula, administer as needed (PRN) oxygen as ordered via O2 concentrator and or etank: via: nasal cannula, provide resident/responsible party education PRN to include: coughing/deep breathing, fluid needs, pursed-lip breathing, need for rest, compensatory strategies, and encourage compliance with O2 therapy. It continues R3 has an Activities of Daily Living (ADL) self-care performance deficit. Interventions: The resident is independent/set up and able to move and reposition in the bed but check with the resident every few hours to remind and assist if needed, Bed Mobility: Supervision-Independent, Transfer: Supervision-Independent, Walking: Supervision-Independent, Eating: Independent, Bathing: Supervision. R3's Minimum Data Set (MDS), dated [DATE], documents R3 had a moderate cognitive impairment and required setup or clean up assistance for most ADLs. (continued on next page)

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/24 at 12:19 PM, V5, Registered Nurse (RN) stated I was the emergency room (ER) Nurse who took care of (R3) when he went to theER on [DATE]. (R3) was very hypoxic upon arrival to the hospital with the Fire Department getting an oxygen saturation of 65%. The Emergency Medical Service (EMS) guys told us that the Nurse at the facility who was taking care of (R3) knew nothing about him and stated she was just a temp there working. No one at the facility was able to tell EMS when (R3) was last seen well, or how long he was like that. The facility gave EMS paperwork that indicated (R3) was a Full Code, so we intubated (R3) in attempts to resuscitate him. The facility did not call (R3's) brother, who was also his Power of Attorney (POA/V6), to let him know they were sending (R3) to the ER, and when (V6) showed up at the facility to see (R3), he was told that (R3) was taken to the hospital. Then (V6) showed up at the ER and saw (R3) intubated, he told us that (R3) was a Do Not Resuscitate (DNR) and that he did not want to be intubated. He told us they signed the appropriate paperwork back in June 2024 for that, and he provided that paperwork to the facility, and they should have sent that. The ER Physician had to withdraw care and let R3 pass away. On 8/19/24 at 12:40 PM, V6, R3's Brother/POA, stated I went to the facility to check on (R3) on 8/16/24. When I got to the facility, I went to (R3's) room, and he was not there and his roommate stated that they took (R3) to the hospital. When I asked, it took three different staff members just to tell me which hospital he went to. When I got to the ER, I found out that the hospital had intubated (R3) and they should not have done so because (R3) was a DNR/Do Not Intubate (DNI). The ER Nurse showed me the paperwork from the facility that was sent with (R3) and it did show that (R3) was a Full Code. I signed paperwork in June 2024 with (R3) indicating that (R3) was a DNR and the facility should have had that in his record, but they sent the wrong one. I was not happy because my sister and I had to make the decision to terminate (R3's) care, so they extubated (R3) and let him pass away. R3's Nursing Note, dated 8/16/24 at 9:53 AM, documents Upon walking past room Therapy stopped me and informed me that the resident didnt look good. Upon assessment resident noted to be in respiratory distress and slow to respond. PA (Physician Assistant) notified and Nurse informed to call 911 and have resident sent to ED (Emergency Department) for eval and treatment. This was documented by the Assistant Director of Nursing (ADON) at that time and is no longer at the facility. There was nothing documented about notifying R3's POA. R3's Hospital Record - page 2, dated 8/16/24, documents [AGE] year-old male with a history of COPD, acute respiratory failure with hypoxia, panlobular emphysema, moderate protein calorie malnutrition, type 2 diabetes, hyperlipidemia, hyponatremia, hypoosmolality, electrolyte imbalance, schizophrenia, dysphagia, hypertension, oxygen dependence that was brought in by EMS secondary to altered mental status and hypoxia. Upon arrival, EMS noted, patient last known well was last night approximately 9:00 PM, however has not been seen until 10:00 AM this morning, all of the nurses at the facility where traveler's and did not know this patient. They did note that he is normally up and smoking however. Upon arrival, EMS noted patient was altered, not following commands, satting in the mid 60s, unsure of how long this has been going on, improved to the 90s with a non-rebreather. No family is at the bedside. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's Hospital Record - page 13, dated 8/16/24, documents Spoke with the brother (V6) at the bedside, he notes the patient was a DNR and has a very poor quality of life over the last number of days to weeks. He states the signed paperwork is at the facility however the paperwork we initially received has him as a full code. He is going to call his sisters, although he is the POA, to confer and decide the next steps at this time. Brother has opted for extubation and removal of care, comfort measures only. Time of death called, ultrasound confirmed cardiac standstill, brother at the bedside, will page his primary care. R3's Hospital Record - Page 17, documents Patient's brother to bedside. Patient's brother states what facility told EMS was not true and patient has been weaker/not normal since Sunday. Patient's brother also states patient is DNR/DNI, brother is POA. [NAME] (ER Physician) to bedside to discuss POC (plan of care) due to paperwork from facility showing full code. 2. R4's Face Sheet, undated, documents R4 was originally admitted to the facility on [DATE] and was discharged on [DATE] with diagnosis of Metabolic Encephalopathy, Fracture Tibia, Mitral Valve Insufficiency, Adult Failure to Thrive, Malnutrition, Pulmonary Hypertension, Anemia, Hypothyroidism, Cardiomyopathy, Gangrene, HTN, Cellulitis Left Lower Extremity (LLE), Rhabdomyolysis, Peripheral Vascular Disease, Congestive Heart Failure, and Acquired Absence of Right Above Knee Amputation (AKA). R4's Care Plan, dated 5/6/24, documents R4 has need/wants for an enabling device. Interventions: Bed in lowest position, call light in reach, Increased frequency of monitoring, mat next to bed, visual and or verbal reminders to use call light. R4 is also noted to be non-compliant at times with transfers. Interventions: Transfers: Mechanical Lift x 2 assist, non-weight bearing to left lower extremity (Fracture) - in knee brace. Right lower extremity has gangrene to foot. Encourage the resident to use bell to call for assistance. It continues R4 is at risk for falls related to her generalized weakness and impaired cognition. Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed, check the environment for clutter or trip hazards and area is well lit, fall risk evaluation, monitor/encourage appropriate footwear PRN, keep bed in lowest position acceptable by the resident when the resident is in bed, remind to request assistance when getting up if needed. R4's MDS, dated [DATE], documents R4 had a moderate cognitive impairment and was dependent on staff for all ADLs. On 8/19/24 at 1:45 PM, V7, R4's family member/friend, stated that R4 was her grandfather's significant other for a long time and R4 became like her own grandmother. V7 stated that her grandfather is POA over R4. V7 stated that in December 2023, or January 2024, R4 was treated for cellulitis in that same leg and finally had a physician figure out that she was having a vascular issue. V7 stated they did an Ultrasound and a CT scan and found that R4 had a femoral artery clot. V7 stated that the physician decided they needed to amputate her right leg and did an AKA. V7 stated that a month or so later, her grandfather got a phone call from the hospital asking for consent for R4 to have surgery. V7 stated that her grandfather visited R4 on a Thursday evening, and no one said anything about R4 having a surgery. V7 stated that next day is when the hospital called wanting consent for surgery to do another AKA of her left leg. V7 stated the facility did not notify her grandfather that R4 was even going to the hospital. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Nursing Note, dated 5/1/24 at 10:47 AM, documents (Nurse) at (Local Hospital) notifed nurse that resident surgery for amputation on Friday May 3, 2024 at 10 AM and to be at hospital at 7:30 AM, resident ready for transport at 6:30 AM. R4's Nursing Note, dated 5/3/24 at 9:52 AM, documents Resident LOA (leave of absence) from facility for surgery at (Local Hospital). There is no documentation of the facility notifying R4's POA prior to transport to the hospital. On 8/20/24 at 9:05 AM, V1, Administrator, stated I was aware that (R3) went to the hospital due to respiratory distress and had passed away in the hospital, but I was not aware of any issues. On 8/20/24 at 12:00 PM, V12, Registered Nurse (RN), stated If I am sending a resident to the ER, I would first make sure I called the physician and got an order, I would print out all of the resident's orders, Physicians Orders for Life Sustaining Treatment (POLST), the transfer sheet, and the facesheet, and will give it all to the EMS. I would call the residents family/POA and let them know what is going on. After the resident leaves the facility with EMS, I will call the ER and give them a report on why the resident is being sent. On 8/21/24 at 10:30 AM, V18, Licensed Practical Nurse (LPN), If I am sending a resident to the hospital and calling 911, I would make sure I call the POA and the Physician, then I would prepare the transfer paperwork including the facesheet, POLST, order summary, and any other pertinent information. If there is a POLST and POA paperwork in the record, I would send both of them. On 8/21/24 at 10:40 AM, V19, LPN, If I was sending a resident to ER via 911, I would call the Physician, check the resident's code status, send all of the orders, and the POLST. I would send the most up-to-date paperwork we have on that resident. I would give report to the EMS, including the resident's age, name, date of birth, any physical changes, how the resident was acting, any allergies, and basically everything I would know about the resident. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Transfer or Discharge, Facility Initiated Policy, dated 10/2022, documents Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy. Notice of Transfer or Discharge (Emergent or Therapeutic Leave): 4. Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content requirements). 7. Nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge. Orientation for Transfer or Discharge (Emergent or Therapeutic Leave): 2. For an emergency transfer or discharge to a hospital or other acute care institution, implement the following procedures: a. Call 911 if the resident meets clinical/behavioral criteria per facility policy, or assist in obtaining transportation; b. Notify the resident's attending physician; c. Orient/prepare the resident for transfer; and d. Prepare for medical record transfer. Information Conveyed to Receiving Provider: 1. Should a resident be transferred or discharged for any reason, the following information is communicated to the receiving facility or provider: a. The basis for the transfer or discharge; b. Contact information of the practitioner responsible for the care of the resident; c. Resident representative information including contact information; d. Advance directive information; e. All special instructions or precautions for ongoing care, as appropriate such as: (1) treatments and devices (oxygen, implants, IVs, tubes/catheters); (2) transmission-based precautions such as contact, droplet, or airborne; (3) special risks such as risk for falls, elopement, bleeding, or pressure injury; and/or (4) aspiration precautions; f. Comprehensive care plan goals; and g. All other information necessary to meet the resident's needs, including but not limited to: (1) resident status, including baseline and current mental, behavioral, and functional status, (2) recent vital signs; (3) diagnoses and allergies; (4)medications (including when last received); (5) most recent relevant labs, other diagnostic tests, and recent immunizations; (6) a copy of the residents discharge summary; and (7) any other documentation, as applicable, to ensure a safe and effective transition of care.

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	08/22/2024

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

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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34964 Based on interview and record review, the facility failed to administer medications as ordered for one of 5 residents (R8) reviewed for medication administration in the sample of 12. Finding include: On 8/21/24 at 8:15 AM R8 stated there is one certain agency nurse who does not come in and give her the 3 little thyroid pills she is supposed to have at 4:30 AM . She stated she did not know who the nurse was and she did not report it to anyone because she couldn't remember when it happened. R8's Minimum Data Set (MDS) dated [DATE] documents R8 is alert and oriented. R8's active Physician Order dated 11/30/23 documents she is to receive Levothyroxine 25 micrograms (mcg) Give 75 mcg by mouth one time a day for hypothyroidism. R8's Medication Administration Record (MAR) dated 8/1/24 to 8/31/24 does not document R8 received her scheduled dose of Levothryroxine on 8/12/24. On 8/22/24 at 10:25 AM V2, Director of Nursing (DON) , stated R8 was in the facility on the morning of 8/12/24 and should have received her Levothyroxine as ordered. V2 stated she would expect all residents to receive their medications as ordered by the physician. The facility's policy, Administering Medications, revised April 2019, documents, Medications are administered in a safe and timely manner, and as prescribed.