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	07/29/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to implement a resident's bed mobility care plan and failed to have the proper number of staff were present to change the resident's position in bed as directed by the resident's facility-created 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 [DATE], 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 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, 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