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	01/07/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician of a change in condition and holding diabetic medication for 1 of 4 residents (R2) reviewed for notifications in the sample of 4.Findings include:R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including dementia and diabetes mellitus type 2 with hyperglycemia.R2's Physician Order dated 9/10/25 documents Humalog (insulin) Injection Solution per sliding scale at meals and at bedtime for diabetes mellitus type 2 with hyperglycemia. R2's Care Plan initiated 9/15/25 documents R2 has the potential for high and low blood sugar related to diabetes mellitus. R2's Care Plan interventions include diabetes medication and blood sugar checks as ordered by physician.R2's Minimum Data Set (MDS) dated [DATE] documents R2 was cognitively impaired, ambulates with supervision, and R2 received insulin medication.R2's Physician Order dated 9/18/25 documents monitor for signs and symptoms of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar).R2's Medication Administration Record (MAR) does not document R2's blood sugar was checked or Humalog was given on 10/25/25 at 11:30 AM, 10/25/25 at 4:30 PM, 10/25/25 at 9:00 PM, 10/26/25 at 6:30 AM, 10/26/25 at 11:30 AM, or 10/26/25 at 4:30 PM.R2's Progress Notes do not document R2's Physician was notified regarding blood sugars not being checked or insulin not being given.On 10/30/25 at 12:45 PM, V10, Licensed Practical Nurse (LPN), stated on 10/25/25 R2 she was having behaviors and combativeness. She finally went to sleep, and on 10/26/25 she was still sleeping. She did not check R2's blood sugars or give her insulin because she felt sleeping was best for her at that time and did not notify the physician of this.The Facility's Employee Counseling Form dated 10/28/25 documents V10 failed to notify physician of change of condition and failure to provide notification to physician and family.On 10/31/25 at 10:41 AM, V1, Administrator, stated she would expect nurses to notify physician of any changes or missed medications.The Facility's Notification of Changes Policy reviewed 10/28/25 documents, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.The Facility's Medication Errors Policy reviewed 8/21/25 documents the Facility shall ensure medications will be administered according to physician orders. If a medication error occurs, the nurse assessed the resident's condition and notifies the physician or health care practitioner as soon as possible.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Facility failed to ensure a resident with known diabetes received timely blood glucose monitoring per physician orders for 1 of 4 residents (R2) reviewed for quality of care in the sample of 4. This past non-compliance occurred from 10/25/25 to 10/28/25.Findings include:R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including dementia and diabetes mellitus type 2 with hyperglycemia.R2's Minimum Data Set (MDS) dated [DATE] documents R2 was cognitively impaired, ambulated with supervision and took insulin.R2's Care Plan initiated 9/15/25 documents R2 has the potential for high and low blood sugar related to diabetes mellitus. Care Plan interventions include diabetes medication and blood sugar checks as ordered by physician.R2's Progress Note dated 10/26/25 at 4:03 AM documents R2 had been sleeping since the start of shift at 10:00 PM the night before.R2's Physician Order dated 9/10/25 document Insulin Glargine Solution (100 units/milliliter), inject 40 units twice daily related to diabetes mellitus type 2 with hyperglycemia.R2's Physician Order dated 9/10/25 documents Humalog Injection Solution per sliding scale at meals and at bedtime for diabetes mellitus type 2 with hyperglycemia.R2's Physician Order dated 9/18/25 documents monitor for signs and symptoms of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar).R2's Medication Administration Record (MAR) does not document R2's blood sugar was checked or Humalog was given on 10/25/25 at 11:30 AM, 10/25/25 at 4:30 PM, 10/25/25 at 9:00 PM, 10/26/25 at 6:30 AM, 10/26/25 at 11:30 AM, or 10/26/25 at 4:30 PM.On 10/30/25 at 12:45 PM, V10, Licensed Practical Nurse (LPN), stated on 10/25/25, R2 was having behaviors and combativeness. She finally went to sleep, and on 10/26/25 she was still sleeping a lot. She did not check R2's blood sugars or give her insulin because she felt sleeping was best for her at that time.On 10/31/25 at 10:41 AM, V1, Administrator, stated she would expect nurses to monitor blood glucose levels as prescribed by physician.The Facility's Blood Glucose Monitoring Policy revised 9/15/25 documents, It is the policy of this facility to perform blood glucose monitoring to diabetic residents as per physician's orders. The facility will perform blood glucose monitoring as per physician's orders.Prior to the survey date 1/7/2026, the facility took the following actions on 10/28/2025 to correct the noncompliance:1-All residents with diabetic management orders were reviewed to ensure active monitoring schedules were followed. 2-Staff involved were removed from duty pending investigation and retraining.3-Staff failed to recognize the critical importance of adherence to prescribed blood glucose monitoring times.4-On 10/28/25, all diabetic residents requiring blood glucose monitoring had special alert added within the electronic health record (EHR) to generate notification for blood glucose checks. 5-On 10/28/25, facility policy was reviewed and updated to include: All physician-ordered clinical monitoring (including blood sugar checks) must be completed at the ordered time regardless of sleep status unless contraindicated by physician order. by V15, V2, V3, and V1.Ongoing Actions:1-On 10/28/25, V2, V3, V22, V23, and V1 performed mandatory re-education completed for all licensed staff on diabetic management, physician order compliance, and change-of-condition protocols to be ongoing for new hires and agency.2-V2, V3, V22 and V23 audits 100% of diabetic monitoring logs daily for 2 weeks, then weekly for 1 month, then monthly ongoing. 3-Audit results reported during monthly QAPI meetings.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer subcutaneous insulin medication as ordered by a physician for 1 of 4 residents (R2) who had a diagnosis of Diabetes Mellitus Type 2 with Hyperglycemia, reviewed for medication in the sample of 4. Findings Include:R2's Face Sheet documents R2 was admitted to the facility on [DATE] with diagnoses including Dementia and Diabetes Mellitus Type 2 with Hyperglycemia.R2's Minimum Data Set (MDS) dated [DATE] documents R2 was cognitively impaired and took insulin.R2's Care Plan initiated 9/15/25 documents R2 has the potential for high and low blood sugar related to diabetes mellitus. Care Plan interventions include diabetes medication and blood sugar checks as ordered by physician.R2's MAR (Medication Administration Record), dated 10/1/25 - 10/31/25, documents an order dated 9/10/25, for Insulin Glargine Solution 100units/ml (milliliters). Inject 40 units twice daily. The MAR documents that this was not given on 10/25/25 at 8:00 AM, 10/25/25 at 8:00 PM, or 10/26/25 at 8:00 AM.R2's MAR, dated 10/1/25 - 10/31/25, documents an order dated 9/10/25, for Humalog Insulin, inject as per sliding scale before meals and at bedtime. The MAR documents that this was not given on 10/25/25 at 6:30 AM, 10/25/25 at 11:30 AM, 10/25/25 at 4:30 PM, 10/25/25 at 9:00PM, 10/26/25 at 6:30 AM, 10/26/25 at 11:30 AM, and 10/26/25 at 4:30 PM.R2's MAR, dated 10/1/25 - 10/31/25, documents an order dated 9/18/25 to perform (blood glucose monitoring) before meals and at bedtime. The MAR documents this was not completed on 10/25/25 at 11:30 AM, 10/25/25 at 4:30 PM, 10/25/25 at 9:00 PM, 10/26/25 at 6:30 AM, 10/26/25 at 11:30 AM, and 10/26/25 at 4:30 PM. R2's Progress Note, dated 10/26/25 at 6:00 PM, documents the following: Called to room by CNA (Certified Nursing Assistant) to assess resident per resident's daughter at bedside, stated Mom is clammy. VS (vital signs) taken 97.0; 74; 14; 90/70. First (blood glucose check) performed read 230. Unable to arouse resident. Shallow breathing noted, when this writer voiced concern of breathing patter, daughter stated That is the way mom breaths when she's sleeping. Nurse manager notified. R2's Progress Note, dated 10/26/25 at 6:05 PM, documents the following: Second (blood glucose check) obtained at this time with results reading HI.On 10/31/25 at 10:41 AM, V1, Administrator, stated she would expect insulin to be given as ordered. The Medication Error Policy, with a revision date of 8/21/25, documents the facility shall ensure medications will be administered according to physician's orders.