

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER LA Bella of Edwardsville		STREET ADDRESS, CITY, STATE, ZIP CODE 6277 Center Grove Road Edwardsville, IL 62025	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34964 Based on observation, interview and record review, the facility failed to obtain a treatment order and have treatments and interventions in place as ordered by the physician to treat pressure ulcers for 2 of 3 residents (R3 and R4) observed for pressure ulcers in the sample of 7. Findings include: 1. On 3/29/24 at 12:50 PM, R3 was lying in bed on a low air loss mattress. The mattress was not on and there were no lights lit up on controls and no alarm sounding. R3's mattress was still firm and inflated. R3 was lying on his back with the head of his bed up. His tube feeding was infusing per a pump. V7, Certified Nursing Assistant (CNA) came into R3's room to check on R3 and was asked about the mattress not being on . She checked the plug and stated it was unplugged and plugged it back in. V7 stated she was surprised it was not alarming since it was unplugged. She stated she was not sure when someone had last been in to see R3. V7 did roll R3 to his left side and a dressing was observed loosely covering his stage 4 sacral pressure ulcer on his coccyx. When V7 rolled him, the dressing partially came off and pressure ulcer was observed. The wound base of the pressure ulcer was observed to be mostly covered with yellow slough and there was a moderate amount of yellowish-green drainage on old dressing and some on his pad on his bed. R3's Face Sheet, printed 4/4/24, documents his diagnoses to include Non-traumatic Intracerebral Hemorrhage, Spastic Quadriplegic Cerebral Palsy, Type 2 Diabetes Mellitus, Anemia, and Unspecified Protein-Calorie Malnutrition. R3's Minimum Data Set (MDS) dated [DATE] documents R3 had no pressure ulcers at that time. R3's MDS dated [DATE] documents R3 had an unstageable pressure ulcer that was present on readmission. R3's current MDS dated [DATE] documents R3 is severely cognitively impaired, is dependent on staff for all Activities of Daily Living (ADLs), is always incontinent of bowel and bladder, and continues to have a Stage 4 pressure ulcer that was present on admission. R3's Care Plan dated 2/16/24 documents: Resident has area of skin impairment. admitted with pressure area from hospital. Goal: (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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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident will be free from complications related to skin impairment. Resident will not develop any new areas of skin breakdown. Resident's area of skin impairment will remain free from infection. Interventions: Administer/apply medications, ointments, creams as ordered- see MAR/physician orders. Assist with turning and positioning if resident is unable. Consult/make referral for therapy screen as needed. Consult/make referral for wound specialist as needed. Encourage good nutrition and hydration in order to promote healthy skin. Monitor extremity for color, warmth, sensation and/or swelling as needed. Monitor labs as ordered. Provide supplemental protein, amino acids, vitamins, minerals as ordered by physician to promote wound healing (see physician's orders). Report changes in skin status (i.e. s/s infection, non healing, new areas)to nurse/physician. Low air loss mattress applied to bed. Position with pillows to maintain proper body alignment as needed. Sees Wound Physicians R3's Readmission nursing assessment dated [DATE] documents R3 has a wound to coccyx measuring 10 centimeter (cm) x 10.5 cm x 1.5 cm. Under additional comments, this assessment documents, (V13, Wound Physician) to follow. R3 was readmitted to the hospital on 2/5/24 (the next day) and was hospitalized through 2/13/24. R3's Readmission nursing assessment dated [DATE] documents he had a skin condition to sacrum measuring 10cm x 10.5 cm x 1.5 cm. Under comments it documents, Hospital Acquired. (V13) to follow. R3's Physician Order dated 2/16/24 documents: Silver Sulfadiazine 1% mixed with collagen powder, covered with calcium alginate and border dressing QD (every day) and prn (as needed). (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No physician orders for pressure ulcer treatment to R3's Stage 4 pressure ulcer were documented from 2/13/24 to 2/16/24 on R3's Physician Order Summary and R3's Treatment Administration Record (TAR) dated February 2024 does not document any treatment being started until 2/17/24, 3 days after R3's readmission to the facility. On 3/29/24 at 1:30 PM V5, Wound Nurse, stated V7, CNA, told her about R3's mattress being unplugged and that is not alright. On 4/2/24 at 10:40 AM V13, Wound Physician, was here to see R3 today. V13 stated because R3 is on a continuous air flow mattress he should not need to be turned and repositioned as often because the bed should be taking care of redistributing his weight for him. V13 stated the down side of the alternating air flow mattresses is that sometimes residents are rolled out of bed by the mattress. He stated that if the bed was unplugged, the machine should have been alarming . On 4/4/24 at 10:15 AM V5, Wound Nurse stated she did not know why there was no order for a treatment to R3's pressure ulcer on his coccyx when he returned from the hospital on 2/13/24 and treatment not started until 2/17/24. She stated the nurse who admitted him on 2/13/24 should have notified the doctor for a treatment order if there was no orders for wound care on the hospital discharge orders. The facility's policy, Identification of Changes in Skin Condition, A Quick Reference Tool undated, documents, Assessment and Treatment of Pressure Ulcers: It is important that each existing pressure ulcer be identified, whether on admission or developed after admission, and that factors that influenced its development, the potential for development of additional ulcers or for the deterioration of the pressure ulcer (s) be recognized, assessed and addressed. Any new pressure ulcer suggests a need to reevaluate the adequacy of the plan for preventing pressure ulcers. The facility's policy, Standards and Guidelines: SG Wound Care, revised 3/27/21 documents, Standard: It will be the standard of this facility to provide assessment and identification of residents at risk of developing pressure injuries, other wounds and the treatment of skin impairment. 6. Wound care procedures and treatments should be performed according to physician orders. 49578 2. R4's Face Sheet printed 4/5/2024 lists her diagnosis to include: Pressure Ulcer of Sacral Region Stage 4; Chronic Non-pressure Ulcer to the right foot with unspecified severity; Unspecified Dementia with Mild Agitation; Type 2 Diabetes Mellitus with foot ulcer; Non Pressure Ulcer to the right foot with necrosis to the muscle; Venous Insufficiency Chronic Peripheral; Irritant Contact Dermatitis due to friction or contact with other specified body fluids. R4's MDS (Material Data Set) dated 1/9/2024 documents she requires extensive assist of 2 staff with bed mobility, transfers, dressing, eating, toilet use and hygiene. R4's Care Plan dated 5/12/2023 and revision of 11/6/2023 stated she was admitted with a pressure injury to the sacrum from the hospital. Interventions for this care plan documents to report any changes in skin status (infections, non-healing, new areas) to the physician/nurse. Wound care as ordered by the physician see TAR (Treatment Assessment Record). Position with pillows to maintain proper body alignments. Low air mattress to bed with bolsters. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Wound Physician Progress Note dated 2/27/2024, documents her stage 4 pressure ulcer to sacrum measured 1.8 cm length X 1.2 cm width x 0.2 cm in diameter. Surface area 2.16 cm Stage 4. Duration is greater than 282 days. Wound progress at goal. Exudate is moderate serous. Granulation tissue 100%. On 4/4/2024 at 8:35 AM V5, Wound Nurse, removed R4's adult brief to perform a pressure ulcer treatment to stage 4 pressure ulcer to sacrum. When R4's adult brief was removed there was no dressing in place to her pressure ulcer. R4's adult brief had stool on it. R4's wound bed observed to be about nickel sized red and moist with no foul odor detected. On 4/4/2024 at 8:55 AM V18 CNA, V19, CNA, and V20 were interviewed regarding R4's treatment not being done on her pressure ulcer. V18 stated that she has the resident R4 and checked her this morning and she was dry with no ADL care given at that time. V19 stated that she does not have the resident R4 and has not performed any care on her today. V20 stated that she does not have the resident R4 and works on another hall, and is just helping and denies doing any perineal care to R4 this morning. V5 stated that she was unaware of how long R4's dressing was off on her stage 4 ulcer to sacrum area. The facility's policy, Identification of Changes in Skin Condition, A Quick Reference Tool undated, documents, Assessment and Treatment of Pressure Ulcers: It is important that each existing pressure ulcer be identified, whether on admission or developed after admission, and that factors that influenced its development, the potential for development of additional ulcers or for the deterioration of the pressure ulcer (s) be recognized, assessed and addressed. Any new pressure ulcer suggests a need to reevaluate the adequacy of the plan for preventing pressure ulcers. The facility's policy, Standards and Guidelines: SG Wound Care, revised 3/27/21 documents, Standard: It will be the standard of this facility to provide assessment and identification of residents at risk of developing pressure injuries, other wounds and the treatment of skin impairment. 6. Wound care procedures and treatments should be performed according to physician orders.		