

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 11/06/2025
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure housekeeping services were provided to maintain a clean and sanitary environment for 9 of 14 (R3, R8, R16, R17, R18, R19, R20, R21, R22, R23) residents reviewed for housekeeping on the sample list of 23. Findings include: The Resident Council Meeting Minutes, dated 9/10/2025, documents that New News Housekeeping/Laundry: Resident have concerns about shower rooms not being mopped. The Resident Council Meeting Minutes, dated 10/15/2025, documents that New News Housekeeping/Laundry: Resident have concern about floors being dirty/sticky. On 10/27/2025 from 9:05 AM to 9:18 AM a tour was performed on 100 hall and 200 hall revealed: 1. room [ROOM NUMBER], R16's and R22's room, had large torn pieces of incontinent briefs, food green beans and potatoes, and empty diet Coke bottle on floor. The floor was sticky when waking on it. 2. room [ROOM NUMBER], R19's and R23's room, large torn pieces of incontinent briefs, soiled undergarments in trash can, strong urine odor in room and hallway. Flies observed in room on bed. 3. room [ROOM NUMBER], R20's and R21's room, Strong urine odor immediately upon walking to doorway. Floor sticky and shoes sticking to floor when walking in room. Food on floor mat and floor of room. 2:26 PM Floor remains sticky with food on mat and floor. 4. room [ROOM NUMBER], R17's and R18's room large torn pieces of incontinent briefs on floor, used gloves on floor. On 10/23/2025 at 2:28 PM V6, R3's daughter, stated that she visited her father for several days. V6 stated that on day 1 she came to the facility and her father was hanging out of the bed with his catheter tangled around his legs. V6 stated that there were a pair of urine-soaked pants hanging in the bathroom and R3 was laying in feces. V6 stated that on day 2 the pants remained wet and hand hanging in the bathroom. V6 stated that the floor was sticky with dirt and food on the floor. V6 stated that on Day 4 the floor remained sticky, and the same dirt and food remained on the floor. V6 stated that she asked the staff about the floor and did not get a response. On 10/23/2025 at 2:55 PM R1 stated that housekeeping does not clean her room every day. R1 stated that the floors are not mopped every day. R1 stated that they don't clean to her standards. R1 stated that she has her own hand dust mop and does some cleaning herself. R1's Minimum Data Set (MDS), dated [DATE], documents that R1 is moderately cognitively impaired. On 10/27/2025 at 9:00 AM V5, Housekeeper, stated that she is assigned a specific area to clean each day. V5 stated that she cleans and mops the residents' rooms that she is assigned daily. V5 stated that cleaning the rooms and mopping the floor daily is apart of her daily duties. On 10/27/2025 at 9:12 AM V7, Certified Nurse's Assistant (CNA), stated that housekeeping does come on the hall but not every room is cleaned. On 10/27/2025 at 1:10 PM R11 stated that the room are not cleaned every day. R11 stated that they have gotten better but it's not every day. R11 stated that her floor is sticky for days and sometimes it gets cleaned up and sometimes it doesn't. On 10/27/2025 at 2:24 PM R17 stated that her room is not cleaned every day. R17 stated that they do come from time to time and mop the floor and wipe stuff down but not daily. R17's sIDT IPOC (Care Plan/Care Conference), dated 10/2/2025, documents that R3 is alert and oriented x3 with little confusion. R11's 72 HR Occurrence F/U Charting, dated 10/6/2025, documents that R11 is alert and oriented. On 10/27/2025 at 1:16 PM R10 stated that he is the vice president of resident council. R10 stated that it is a concern of the cleanliness of the facility. R10 stated that housekeeping does not consistently clean the rooms as they should. R10 stated that the rooms are not cleaned daily. R10's MDS, dated [DATE], documents that R10 is cognitively intact. On 10/27/2025 at 3:10 PM V12, Housekeeping Supervisor/Assistant, stated that daily the residents' room are to be deep cleaned. V12 stated that the trash is pulled, the high and low touch areas are cleaned, and the floors are mopped. V12 stated that this includes the bathrooms. V12 stated that they clean the hallways and common areas daily. V12 stated that they have not been able to clean the resident rooms because they are short of staff. V12 stated that this is what happened today. V12 stated that they have had staff quit, not come to work, or don't work when at facility. V12 stated that they are actively hiring. V12 stated that they have job listings on websites. On 10/28/2025 at 9:47 AM V14, Social Service Director, stated that she was notified of V6's concerns 40 minutes after being posted on the internet. V6 stated that she was a little shocked because she had been in communication with V6 throughout R3's stay and this had not come up. V6 stated that R3 did have concerns of the cleanliness of the building, R3's bedroom floor being sticky and R3's catheter being tangled. V6 stated that she called up to the facility for them to address the concerns and informed V6 that she would have management give her a call on the following day. The facility's Daily Resident/Patient Room Cleaning Procedure, not dated</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess and implement appropriate fall intervention for 1 of 3 (R3) residents reviewed for falls in a sample list of 28. This failure resulted in R3 experiencing an unwitnessed fall, sustaining a laceration to his forehead requiring 8 sutures by local hospital. Findings include R3's Care Plan, dated 10/22/2025, documents that R3 at risk for falls. The resident has impaired cognition and impaired safety awareness. The resident has balance or walking impairments. The resident has a history of falls., The resident has FUNCTIONAL IMPAIRMENTS OF THE LOWER EXTREMITIES which causes safety issues with transfers and/or walking. Interventions anticipate and meet resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Fall RISK evaluation. Frequent monitoring of resident to ensure safe positioning and needs are met. Keep bed in lowest position acceptable by the resident when the resident is in bed. Turn and reposition. Visual and or verbal reminders to use call light. Family does not want resident to sit up for more than 30 minutes at a time. Discussed with family importance of sitting up for longer intervals to improve resident's strength. R3's Minimum Data Set, dated [DATE], documents that R3 is severely cognitively impaired and dependent on staff for mobility. R3's Fall Assessment, dated 10/15/2025, documents that R3 is high risk for falls. R3's admission Assessment, dated 10/16/2025, documents that R3's has unsteady gait requiring supervision, impaired balance, and has weakness. R3's Progress Note, dated 10/21/2025 at 4:47 PM, documents that Nursing staff request this NP evaluate the patient after a ground-level fall with injury. Nursing staff report patient was sitting in his wheelchair waiting the CNA to bring him to the shower. Staff report he was left alone no longer than 4 min. Patient stood up and attempted to walk and lost his balance and his head on the doorknob. He sustained a laceration to his forehead and a puncture wound to his upper lip just beneath his nose. Pressure was applied to his forehead laceration and bleeding had stopped prior to this NP's arrival at bedside. R3's Fall Report, dated 10/21/2025 at 1:15 PM, documents that Incident Description: Nursing Description: This nurse heard a boom and walked down hallway to find resident crawling on floor towards door. Resident Description: Resident Unable to give Description. Was this incident witnessed: N (no). Mental status: oriented to person and situation. Injury type/location: laceration/Face. Notes: resident noted to have a laceration in the middle of his forehead. Predisposing Physiological Factors: Confused and Impaired Memory. Predisposing Situation Factor: Ambulating without assist. Other Info: R3 was in bed after lunch, family requested that he be returned to bed following meal. Family left shortly before resident was returned to bed. Nurse heard noise in room -when she entered room, resident was seen crawling on the floor next to his bed. Resident had sustained a laceration to the middle of his forehead. On 10/23/2025 at 2:28 PM V6, R3's daughter, stated that she and her family visited R3 several days during his stay at the facility. V6 stated that on the day of his fall R3 was up in his wheelchair in the dining room. V6 stated that they were happy about this because R3 had been in the bed at the hospital for 5 weeks. V6 stated that they noticed that R3 was agitated, moving, yelling, and felt maybe the environment was overstimulating for R3. V6 stated that they asked if he could lay down after his meal and was told that this was possible. V6 stated that the family left. V6 stated that shortly after she received a call that R3 fell out of the bed and fell to the floor. V6 stated that she was informed that R3 was crawling on the floor with blood coming from head. V6 stated that she was informed that R3 would be sent to hospital due to having a cut on his head. V6 stated that she was informed that they knew R3 wouldn't stay in the bed and that is why they took his wheelchair out of the room. On 10/27/2025 at 12:50 PM V9, Licensed Practical Nurse, stated that she was R3 nurse on the day of his fall. V9 stated that the family was visiting and requested that R3 lay down after his meal. V9 stated that R3's family left and R3 stayed in the dining area until he started throwing cups and things. V9 stated that R3 was at that time removed from the dining area. V9 stated that she and V18, Certified Nurses' Assistant, assisted R3 into the bed. V9 stated that R3 was restless, not wanting to stay in the bed and not wanting to be in the chair. V9 stated V18 said that R3 needed a sitter. V9 stated that when admitted they didn't say he needed one. V9 stated that she informed V18 that she would have to talk with management. V9 stated that she informed V18 to go and take care of her other residents. V9 stated that she stayed and tried to calm R3 and keep him still and not trying to get out of the bed. V9 stated that she thought she had calmed and left the room. V9 stated that she made it to the nurses' station and heard a noise. V9 stated that she headed down the hall and saw R3 crawling on the floor with blood coming from head. On 10/28/2025 at 9:52 AM V15, CNA</p>		