STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145846	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Bella of Edwardsville	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** Based on interview and record review the facility failed to ensure newly identified pressure wounds were assessed and failed to follow physician orders for administration of treatments to pressure wounds for two (R3 and R7) of four residents reviewed for pressure wounds in the sample list of 10.1.R3's undated Care Plan documents R3's diagnoses include Severe Protein-Calorie Malnutrition, Pressure Ulcer to Right Heel, Open Wound to Right Foot, Muscle Weakness, and Parkinson's Disease. This Care Plan further documents an admission date of 03/15/2025. R3's Care plan dated 12/04/2025 documents a Focus to Document Pressure Ulcer with interventions to evaluate skin for areas of blanching or redness, evaluate ulcer characteristics, monitor bony prominences for redness, and provide wound care per treatment orders. R3's Care plan dated 5/20/2026 documents R3 has decreased mobility with functional limitation in range of motion to bilateral upper extremity (BUE)/ bilateral lower extremity (BLE) related to: Parkinson's Disease. R3's Care Plan dated 3/6/2026 documents R3 had actual skin impairment. Left buttock-pressure 7/7/25; Right heel-pressure 7/7/25; Left lateral buttock 2/4/26; Right pad of foot 2/16/26; Ball of right foot 3/6/2026. R3's Minimum Data Set, dated [DATE] documents R3 has moderate cognitive impairment. R3's Health Status Note dated 3/19/2026 documents nurse completed (R3's) treatment, upon assessment, Left foot edema was noted to be present, as well as Right back side pressure injury that was red and warm to touch, Right hip side red and warm to touch, and a blister noted to the Right knee. (R3) was repositioned to the Left side, with pillows under and in-between (R3's) knee(s) as well as a wedge to keep (R3) off of (R3's) buttock. (R3) is resting in bed, with call light in reach. No distress noted at this time and (V28) Nurse Practitioner (NP) has been notified. R3's Provider Note written by V28 dated 3/19/2026 documents (R3) is being seen acutely today as nursing staff report that (R3) continues to decline. Now with reports of worsening reddened areas on certain pressure points. Erythema noted to right hip, erythema and blistering noted to right knee, some erythema noted to bony prominences to left foot. (R3) appears to have several new reddened skin areas to several different pressure points, concerns with possible Kennedy terminal ulcer to the left heel monitor and notify provider of any further acute changes in condition. On 6/29/2026 at 1:23 p.m., V15 Licensed Practical Nurse (LPN) stated on 3/19/2026, V15 observed a new skin concern with R3. V15 stated R3 had non blanchable redness to left foot and right hip, and a blister to the right knee. V15 stated V15 notified V28 and was advised to refer to V5 Wound Nurse. (continued on next page)

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	V15 confirmed V15 reported the new skin concern to V5 and V5 stated V5 will take care of the new skin issues. V15 stated V15 was not aware of any interventions after V15 reported the new skin issues to V5. V15 stated any newly identified skin issues should have treatment orders as soon as they were identified and they should be recorded to be measured weekly. V15 confirmed there was no treatment or records of the new wounds after V15 reported the skin concerns to V5. On 6/29/2026 at 12:08 p.m., V12 LPN stated each wound should have their own treatment order on Treatment Administration Record (TAR) for nurses to refer for continuity of care. V12 stated if V12 gets the order directly from the provider, V12 puts the order in, otherwise V5 puts the treatment orders in. V12 stated newly observed wounds should be assessed and measured upon initial observation and then weekly thereafter. On 6/30/2026 at 12:25 p.m., V23 Registered Nurse stated treatment orders for any skin issues should be entered and implemented on the day the wounds were identified. V23 stated wound treatments should not be delayed. V23 stated skin issues including pressure ulcers should be assessed, measured and recorded upon identification. V23 stated wounds are being assessed weekly by V5 wound nurse. On 6/30/2026 at 3:10 p.m., V28 Nurse Practitioner (NP) stated R3 had existing pressure wound prior to the visit on 3/19/2026 and confirmed the new areas noted on V8's documentation on 3/19/2026 were newly identified pressures wounds. V28 confirmed the orders V28 provided for these newly identified pressures wounds for R3 was to monitor them and notify V28 if there were changes. V28 stated V28 expects separate wound treatments for each wound to be in place in R3's physician's orders for continuity of care. V28 stated wound treatments should be implemented as soon as the wounds were identified. On 6/30/2026 at 9:49 a.m., V5 Wound Nurse stated each wound should have their own separate treatment orders. V5 stated if there were new skin issues, it should be reported, recorded and the provider notified. V5 stated wounds should be measured and recorded upon initially identifying. V5 stated the treatment order should be entered in the resident's individual chart on the day the wound was initially observed. On 6/30/2026 at 12:38 p.m., V5 Wound Nurse stated there were no treatment orders to R3's new reddened areas and blister identified on 3/19/2026 because they do not do anything with an unopen pressure wounds except to monitor. V5 confirmed V28's recommendation to monitor the new skin issues on V28's provider notes dated 3/19/2026 was considered a physician order and should have been entered as physician's order under Treatment Administration Record (TAR). V5 confirmed nurses refer to the TAR for providing treatment and interventions for continuity of care. 2. R7 was admitted to the facility on [DATE] with documented medical diagnoses including Type 2 Diabetes Mellitus, Parkinson's disease, and Mild Protein-Calorie Malnutrition. The clinical admission referral packet dated 2/11/2026 documented an unstageable vascular wound to the left outer foot and a surgical wound to the left second toe following prior amputation. The first woundˆcare orders entered into R7's electronic health record were dated 2/18/2026 with a start date of 2/19/2026 at 0700 for the left second toe. Additional wound care orders were entered on 2/19/2026 with a start date of 2/20/2026 at 0700 for the left fifth toe wound. A revision order entered on 2/18/2026 for the left fifth toe was discontinued on 2/19/2026 at 11:06 AM. Review of the February Treatment Administration Record showed these treatments were documented as completed (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily beginning on their respective start dates. On 6/29/2026 at between 12:10PM and 12:54PM, V2 (Director of Nursing), V5 (Wound Nurse), and V29 (Licensed Practical Nurse) stated that the admitting nurse is responsible for entering wound care orders upon admission. V2, V5 and V29 reported that when discharge orders are unclear or incomplete, the admitting nurse contacts the facility's Medical Director for guidance. On 6/29/2025 at 12:54PM, V5 stated that if wound care instructions upon admission are incomplete, nursing staff are expected to obtain specific orders and enter them into the electronic health record at that time. V5 stated that V5 or the weekend wound nurse performs follow-up wound and skin assessments the day after admission or after a weekend admission. V5 confirmed that R7 was admitted with a Stage 3 pressure ulcer to the left outer foot and a surgical wound to the left second toe. She stated that R7's discharge paperwork from the hospital indicated continue wound care but did not specify treatments. On 6/29/2026 at 2:00 PM, V5, the Wound Nurse, provided a wound-care script dated 2/14/2026 signed by V35, Medical Doctor, instructing staff to cleanse the left second toe and left lateral foot daily with wound cleanser and apply a foam pad until assessed by wound care nurse. Review of R7's February 2026 Physician Orders Sheet (POS) and Treatment Administration Record (TAR) showed no wound care orders entered or in effect from 2/14/2026 through 2/18/2026. On 6/30/2026 at 2:15PM, V5 acknowledged that although the 2/14/2026 physician script clarifying wound care orders was uploaded into the chart under miscellaneous documents, no corresponding wound care orders were entered into the electronic health record, and therefore no wound treatments were in place from 2/14/2026 to 2/18/2026. V5 confirmed that the three wound care orders dated 2/18/2026 and 2/19/2026 were the only orders placed, and that the start dates were accurate. V5 acknowledged that R7 had no wound care orders implemented during the first five days following admission. The facilities Pressure Injury Prevention and Management policy revised on 12/28/2025 documents wound treatments will be provided in accordance with physician's orders and Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. Findings should include type of wound, wound measurements (measured upon discovery and at least weekly thereafter), other wound characteristics (color, exudate, odor, pain, tissue type in wound bed), and treatment and interventions implemented.