

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

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

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 05/21/2024
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42834 Based on Interview and Record Review, the facility failed to respond to resident needs in a timely manner, by not responding to call lights, and call light not in working order for 2 of 2 residents (R41, R46) in the sample of 48. Findings Include: R41's Facesheet documents an admitted [DATE]. Diagnosis include Polyneuropathy, Chronic Respiratory Failure with hypoxia, Chronic Obstructive Respiratory Disease, Generalized Muscle Weakness. R41's Minimum Data Set, MDS, dated [DATE] documents R41 has no cognitive deficits. R41's MDS dated [DATE] documents R41 requires partial/moderate assist with showering. R41's Care Plan dated 12/19/2023 documents R41 is at risk for falls. Interventions include anticipate and meet R41's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Check the environment for clutter or trip hazards and area is well lit. Remind to request assistance when getting up if needed. Call Don't Fall sign placed in R41's room. On 5/17/2024 at 9:00AM R41 stated The call lights take a long time to answer. The worst time is the evening shift. The CNA's leave the premises, and we don't know where they go. My call light is broken, and I was given a bell to use. They can't hear the bell. I ask my room mate to push her call light if I need anything. On 5/17/2024 at 10:10AM, R41's call light pushed and not working. R41 had bell on bedside table. On 5/17/2024 at 10:10AM R93, (R41's roommate), stated Her (R41's) call light has not worked in a long time. If she needs anything I push my call light for her. On 5/17/2024 at 1:35PM, V30, Maintenance Worker stated I did not know anything about R41's call light not working. The system was recently down. R46's Facesheet documents an admitted [DATE]. Diagnosis include Sacrolitis, Muscle Weakness, Heart Failure, Polyosteoarthritis, Pain in hips and Knees, Orthostatic Hypotension. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R46's MDS dated [DATE] documents R46 has no cognitive deficits. R46 is dependent with showering. R46's care plan dated 10/21/2023 documents R46 is at risk for falls. Interventions include be sure the R41's CALL LIGHT is within reach and encourage R41 to use it for assistance as needed. Check the environment for clutter or trip hazards and area is well lit. Remind to request assistance when getting up if needed. On 5/17/2024 at 9:00AM, R46 stated The call lights take a long time to answer. The worst time is evening shift. The CNA's leave and go to get fast food. If I tell the CNA's that someone's call light is ringing, they tell me not to worry about it. On 5/17/2024 at 2:00PM, V28, CNA, stated I answer a call light as soon as I see it on. I haven't been here very long, but I have heard evenings and nights are longer waits. Resident Council records dated 4/10/2024 document Resident had concerns about call light not being answered. On 5/21/2024 at 2:00PM V1, Administrator, stated that all call lights should be working and answered. We recently had a technician out and all call lights should've been working. If not I want my money back. Facility policy dated 9/1/2021 states The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.		

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33110 Based on interview and Record Review the facility failed to perform cardiopulmonary resuscitation (CPR) for 1 of 1 resident (R7) reviewed for CPR in the sample of 48. This failure resulted in R7 not receiving life saving measures according to her Advanced Directives. The Immediate Jeopardy began on [DATE] when R7 did not received CPR. V1, Adminstrator and V2, Director of Nursing were notified of the Immediate Jeopardy on 05//,d[DATE] at 3:14 PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed, and the deficient practice corrected on [DATE]. Findings Include: R7 's Minimum Data Set (MDS) dated [DATE] documents R7 has moderately impaired cognitive skills for daily decision making. R7s Care Plan dated [DATE] documents (R7) Advanced Directives on record Uniform POLST form (R7) goal is If R7 heart stops, or if they stop breathing, CPR WILL be initiated in honor with their FULL code wishes ongoing through next review date. R7's POLST (Uniform Practitioner Order for Life Sustaining Treatment Form) dated [DATE] documents CPR Attempt Cardiopulmonary Resuscitation, full treatment. R7's Physician Order Sheet dated [DATE] documents Advanced Directive: Full Code. R7's Nurses Note dated [DATE] at 22:42 documents nurse assessed guest (R7) at 3:30 PM, guest (R7) had just been laid back down. Nurse gave 4:00 PM med (medication) and pain pill given as well. Guest (R7) drank a cup of boost and stated thank you. At 6:40 PM staff came to nurse and said she believed guest (R7) had passed. Nurse checked and had 100 hall nurse confirm. Time of death 6:45 pm. R7's Nurses Note dated [DATE] at 11:58 AM Skilled Nursing Assessment completed. Vital signs obtained and reviewed. Cognitive assessment indicates resident has no delirium signs or symptoms present. Resident is alert/awake and responsive to verbal stimuli. Resident is able to recall nothing upon prompting. No neurological symptoms present at this time. PT (Physical Therapy) OT (Occupational Therapy), and/or ST (Speech Therapy) being provided. No cardiovascular symptoms noted. No respiratory symptoms noted. Even and unlabored Respirations are even and unlabored. No GI (Gastrointestinal) symptoms noted. Abdomen is soft/normal. No GU (Genitourinary) signs or symptoms noted. No endocrine symptoms noted. Nursing interventions provided throughout the day. Observed for changes in status. Encouraged activity as allowed. Encouraged resident to maintain correct positioning. Changed position for pressure offloading. On [DATE] at 1:45 PM, V11, Certified Nursing Assistant (CNA) stated, No I don't know anything about that she looked like she was going to die. She didn't want to eat. The other girl told me she had passed, They came in the shower room and told me. (continued on next page)		

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 2:30 PM, V14, Registered Nurse (RN) stated, It was last night her nurse came and got me and asked me to be her second ear. I listened with the stethoscope. I don't know what her and the aide did (question if CPR was done). I was on the 100 halls. No, I didn't know her code status. I don't know the exact time. No, I didn't see the resident (V7) at all before. On [DATE] at 3:10 PM, V12, CNA stated, Right after dinner I went to check her. She had a broken hip, and she wasn't doing great. So, I entered the room, and took one look and knew she was gone. I thought she was hospice. So, I wasn't 100% sure. No ma'am we didn't start CPR. No, the nurse didn't do CPR. It's (code status) on the point click care on the chart. I don't know for sure where else it is. They don't have anything posted on the door. It's a HIPPA (Health Insurance Portability and Accountability Act) violation to post things on the door. The day before she threw up. She was declining. The nurse said before dinner. She spoke to the nurse. I didn't see her until after serving in the dining room, when I checked on her. On [DATE] at 3:40 PM, V13, Licensed Practical Nurse (LPN) stated, Well, I was the nurse on duty. I had been on vacation when she fell . I went in and gave medication and a pain pill at 4:00PM. She looked terrible when they laid her down. She drank a cup of boost, and she said thank you. I checked on her 45 minutes later. She look like she was sleeping, about 6:40 PM (V12) said she had passed. I grab my stethoscope. I couldn't find a pulse. I text the doctor and he said to call hospice and give his condolences to the family I really don't know where my head was. She wasn't on hospice. I talked to the son and he said she wasn't on hospice. He said I will be there in 30 minutes. She was completely cold. I didn't do CPR and yes, I'm CPR certified. On [DATE] at 8:10 AM, V15, CNA, stated in the event of an emergency she will notify the nurse or supervisor and find out what is going on with the resident. Stated she is CPR certified. On [DATE] at 8:13 AM, V16, RN, stated in the event of an emergency someone will stay with the resident while another checks code status. If they are a full code, they start CPR and the other person calls 911. Once EMS comes and takes the resident, they notify the doctor and family. If there is no POLST they are automatically a full code. Stated there is a binder that lists code status and you can also find it on the EMR. Stated she is CPR certified. On [DATE] at 8:16 AM, V17, CNA, stated in the event of an emergency she stays with the resident and yell out code to coworker. Nurses do CPR. I can start CPR if they tell me to but I'm agency and usually let the nurse find code status. +CPR certified. Stated she would never pronounce a resident dead. On [DATE] at 8:18 AM, V18, CNA, stated if there is an emergency she would tell her nurse. She is CPR certified and could check code status in the chart but depends on her nurse to tell her the code status. V21 LPN, stated she is CPR certified. V21 stated if she found a resident unresponsive she would call for help and not leave the room. V22 CNA, stated she is CPR certified. V22 stated if she found a resident unresponsive she would call code blue and call the nurse. (continued on next page)		

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	V23 CNA, stated she is CPR certified and if she found a resident unresponsive she would call for help. V24 LPN, stated she is CPR certified and if she found a resident unresponsive she would start CPR, call for help, and check status. V25 CNA, states she is CPR certified and if she found a resident unresponsive I would check for a pulse and respirations and call for help. The facility's policy entitled Change in Condition dated [DATE] documents Observe resident during routine care and during monthly, quarterly or annual assessment periods to identify significant changes in physical and mental conditions, orientation, change in vital signs, weights. Any resident's condition is considered to life threatening, and the resident requires immediate medical care, notify the emergency medical system (911). Always make every attempt to honor the resident's wishes regarding hospitalization and end of life issues. Maintain compliance with Advance Directives. The facility's policy entitled Cardiopulmonary Resuscitation dated [DATE] documents If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally a licensed staff member who is certified in CPR shall initiate CPR unless: it is known that a Do Not Resuscitate order that specifically prohibits CPR and or external defibrillation exist for that individual. If The resident's DNR status is unclear, CPR will be initiated until it is determined that there is a DNR or a physician's order not to administer CPR. The team completed the following from [DATE] through [DATE] to validate the facility's abatement plan: V22, V23, V24, V26, V31, V32, V33, and V34 were interviewed about the in-services they received regarding identification of code status in orders and POLST (IDPH (Illinois Department of Public Health) Uniform Practitioner Order for Life -Sustaining Treatment POLST Form wishes, the need to perform CPR and contact 911 for Full Codes immediately, the need to continue CPR until EMS (Emergency Medical Services) arrives and provide documentation with POLST form to EMS. The facilities in-services, policies, and audits were reviewed. The Immediate Jeopardy that began on [DATE] was removed and the deficient practice corrected on [DATE] when the facility took the following actions to remove the Immediacy and correct the noncompliance. 1. Polst Form, Resident orders, and Resident care plans audited on [DATE] by Social Services Director for accuracy. 2. All nurses in-serviced prior to next working shift by the Administrator (V1), LNHA, DON (V2), RN or ADON (V3), RN beginning on [DATE] and on-going via phone education by Administrator/DON/ADON on the facilities Code Status Policy and Procedures, where to find code status for each resident in the Medical Record in Point Click Care and in the Code Status Book in alphabetical order located on each RED crash cart. (continued on next page)		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 45947 Based on interview and record review, the Facility failed to use the services of a Registered Nurse (RN) for at least eight hours daily. This has the potential to affect all 102 residents living in the Facility. Findings Include: The Facility's Staffing List for RN (Registered Nurse), LPN (Licensed Practical Nurse), and CNA (Certified Nurse Aid) hours scheduled was provided from 4/30/24 through 5/13/24. These document the Facility did not have a RN for eight hours on 5/4/24, 5/7/24, 5/8/24, or 5/12/24. On 5/21/24 at 7:20 AM, V1, Administrator, stated she did not have RN coverage on all of those days. She stated the Facility does not have a policy regarding RN staffing, and they just follow the regulations. The Facility's Long-Term Care Facility Application For Medicare And Medicaid dated 5/14/24 documents there are 102 residents living in the Facility.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45947 Based on observation, interview, and record review, the Facility failed to ensure food was stored, prepared, and served in a manner that prevents potential contamination. This has the potential to affect all 102 residents living in the Facility. Findings include: On 5/14/24 at 9:44 AM, there were plastic containers of dry corn cereal and dry rice cereal on the food preparation counter that were not dated or labeled. There was a plastic container of a brown granular substance that was not labeled or dated. On the same counter next to the microwave, there was a stack of plates with dried crusted food particles on top. On 5/14/24 at 9:46 AM, there was a large industrial sized food bin labeled flour under the food preparation counter across from the oven that was not dated. On 5/14/24 at 9:48 AM, in the walk in refrigerator there was a stainless steel container with slices of meat that was not covered, labeled or dated. V5, Dietary Manager, stated, That is pork, and it's going with me (to be thrown out). There was a box of dinner rolls that had been opened, and the plastic inside was not resealed, leaving the contents open to air. The package was not dated upon opening. There was a large plastic container with an orange liquid substance inside that was not dated or labeled. There were six trays full of cups with various colored liquids that were not individually wrapped and were covered with additional meal trays. These liquids were not labeled or dated. There was a pan with ground meat that was covered in plastic wrap. There was no legible date or label on the plastic wrap. V5 stated, That is sausage. We have had problems getting lids and labels from the company. On 5/14/24 at 9:56 AM, in the standing freezer there were six plastic bags of frozen French fries that were not opened, but were not dated upon delivery or removal from the original box. There was a box of sugar cookies, a box of dinner rolls, and a box of biscuit dough. All three boxes had been opened, and the plastic inside was not resealed, leaving the contents open to air. The boxes were not dated upon opening. On 5/14/24 at 10:00 AM, V6, Dishwasher, tested the sanitizer level with a test strip during the final rinse cycle. The strip turned orange which correlated with 0 ppm (parts per million) on the test strip container. V6 stated the test strip should be green which correlates with 100-150 ppm. He stated they are probably out of cleaner, and it probably just needs to be changed. On 5/13/24 at 10:02 AM, V7, Dietary Aid, went to the dish room to get cups. Several of the cups she was taking away had a dark tint inside. V7 stated, They're stained. Sometimes you have to run them through twice; otherwise they come out looking like this. V7 then took the cups out of the dish room to the kitchen. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/14/24 at 10:04 AM, V6, Dishwasher, loaded the dish machine with bowls and ran the machine without changing the cleaner. V6 then rinsed his hands with sanitizing solution from the sink. He did not dry his hands, then went to the bowls that had run through dish machine and put some of them back in the dirty stack. V6 stated, They are still dirty, so I will run them through again. V6 put the remaining bowls from that cycle in the clean stack. On 5/15/24 at 7:53 AM, V7, Dietary Aid, was plating breakfast on the tray line. She handed V5, Dietary Manager, a plate that appeared dirty. V5 took the plate back to dish room. On 5/15/24 at 7:58 AM, V9, Dietary Aid, handed a tray that appeared dirty to V5, Dietary Manager. V5 took the tray to the dish room. On 5/15/24 at 7:59 AM, V7, Dietary Aid, took a tray from the stack of trays being used, then put it back into another stack. She stated, Apparently they didn't wash them good last night. On 5/15/24 at 8:02 AM, V9, Dietary Aid, took a tray with yellow food debris from the stack and put it in the dish room. On 5/15/24 at 8:40 AM, V5, Dietary Manager, stated the repair company is coming in later today to service the dish machine and told him there is probably an issue with the chemicals. V5 stated he was unable to get the sanitizer levels where they needed to be this morning and had to run it three times. On 5/15/24 at 9:55 AM, V5, Dietary Manager, stated the dishwasher is actually a high temperature machine, so it does not use sanitizer, just a detergent. On 5/21/24 at 9:37 AM, V1, Administrator, stated she expects staff to follow all food service policies. The Facility's Food Storage: Cold Policy revised 10/2019 documents, It is the center policy to insure all Time/Temperature Control for Safety (TCS), frozen and refrigerated food items, will be appropriately stored in accordance with guidelines of the FDA (Food and Drug Administration) Food Code. The Dining Services Director/Cook(s) insures that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination. The Facility's Ware washing Policy revised 10/2019 documents, It is the center policy that all dishware and service ware will be cleaned and sanitized after each use. The Dining Services Director insures that the nutrition service staff is knowledgeable in proper technique for processing dirty dish ware to clean through the dish machine and proper handling of sanitized dish ware. The Facility's Long-Term Care Facility Application For Medicare And Medicaid dated 5/14/24 documents there are 102 residents living in the Facility.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33110 Based on interview and record review the facility failed to offer Pneumonia vaccinations for 1 of 5 residents (R42) reviewed for Immunizations in the sample of 48 Findings Include: R42's Minimum Data Set (MDS) dated [DATE] documents R42 is severely impaired for cognitive skills for daily decision making. R42's Electronic Health Record (EHR) Influenza vaccine was given on 10/19/23 and COVID vaccine was given on 12/18/23. R42's EHR did not document a Pneumonia Vaccine. On 5/17/24 V4 Infection Control Preventionist (ICP) stated, They haven't had an IP in a while. I'm focusing on the TB (Tuberculosis) tests, But I will start on vaccinations, I have only been here a month. The facility policy Vaccination of Residents dated October 2019 documents all residents will be offered vaccines that aide in preventing infectious diseases. Unless the vaccine is medically contraindicated or the resident has already been vaccinated		