Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE S COMPLI	
		IL6014401	B. WING		05/2	1/2024
LA BELLA OF EDWARDSVILLE 6277 CENT		RESS, CITY, STA  ER GROVE RO  VILLE, IL 6202	DAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Licensure and	d Certification				
S9999	Final Observations		S9999			
	Statement of Licensu	re Violations				
	300.610a) 300.1035a)4)5) 300.1210a) 300.1210b) 300.1210c) 300.1210d)3)					
	procedures governing facility. The written pube formulated by a Re Committee consisting administrator, the advimedical advisory commof nursing and other supplicies shall comply to The written policies shall be the facility and shall be	nall have written policies and g all services provided by the olicies and procedures shall esident Care Policy g of at least the visory physician or the nmittee, and representatives services in the facility. The with the Act and this Part. hall be followed in operating per reviewed at least annually ocumented by written, signed				
	Every facility right to make decisior medical treatment, ind reject, or limit life-sus:	shall respect the residents' ns relating to their own cluding the right to accept, taining treatment. Every a policy concerning the				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

06/07/24 **Electronically Signed** 

STATE FORM 6899 If continuation sheet 1 of 8 1YBN11

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		IL6014401	B. WING		05	5/21/2024
LA BELLA OF EDWARDSVILLE 6277 CE			DDRESS, CITY, STATE NTER GROVE ROA DSVILLE, IL 62028	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
\$9999	implementation of such this policy shall be:  4) procedures do with respect to the protreatment when a resireject or limit life-susting tresident has failed or opportunity to make the specific provisions of responsible.  5) procedures for indirect care staff in the specific provisions of responsible.  Section 300.1210 Get Nursing and Personal and persona	ch rights. Included within  etailing staff's responsibility ovision of life-sustaining ident has chosen to accept, aining treatment, or when a has not yet been given the nese choices;  In educating both direct and ne application of those the policy for which they are  eneral Requirements for I Care  We Resident Care Plan. A ipation of the resident and nor representative, as elop and implement a colan for each resident that objectives and timetables to edical, nursing, and mental eds that are identified in the sive assessment, which attain or maintain the highest dependent functioning, and planning to the least ed on the resident and the representative, as	S9999			

Illinois Department of Public Health

STATE FORM 1YBN11 If continuation sheet 2 of 8

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6014401	B. WING		05	5/21/2024
	ROVIDER OR SUPPLIER	6277 CEI	DDRESS, CITY, STATE, NTER GROVE ROA DSVILLE, IL 62025			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S9999	well-being of the resideach resident's comp plan. Adequate and p care and personal caresident to meet the trace needs of the resident to meet the trace needs of the resident cand be knowledgeably respective resident cand be seven-day-a-week based on the seven-day-a-week based on the seven-day candidate of the seven-day candidate in the sequirements.  Based on interview and failed to perform cand (CPR) for 1 of 1 resided in the sample of 48. The receiving life saving in Advanced Directives.  Findings Include:	mental, and psychological dent, in accordance with rehensive resident care roperly supervised nursing re shall be provided to each otal nursing and personal ident.  The are-giving staff shall review e about his or her residents' are plan.  The about his or her residents' are plan.	\$9999			
		Set (MDS) dated 2/20/24 oderately impaired cognitive				

Illinois Department of Public Health

STATE FORM 6899 1YBN11 If continuation sheet 3 of 8

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6014401	B. WING		05	5/21/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
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LA BELLA	A OF EDWARDSVILLE		OSVILLE, IL 62025			
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S9999	Continued From page	3	S9999			
	skills for daily decisio	n making.				
	R7"s Care Plan dated 2/20/24 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.					
	Sustaining Treatment	n Practitioner Order for Life Form) dated 4/10/23 mpt Cardiopulmonary atment.				
	R7's Physician Order Sheet dated 2/1/24 documents Advanced Directive: Full Code.					
	PM, guest (R7) had ju Nurse gave 4:00 PM pill given as well. Gue and stated thank you nurse and said she be	essed guest (R7) at 3:30 ust been laid back down. med (medication) and pain est (R7) drank a cup of boost At 6:40 PM staff came to elieved guest (R7) had ed and had 100 hall nurse				
	Skilled Nursing Assessings obtained and reassessment indicates signs or symptoms pralert/awake and response alert/awake and response Resident is able to reason neurological symper (Physical Therapy Therapy), and/or ST (provided. No cardious No respiratory symptoms)	resident has no delirium resent. Resident is consive to verbal stimuli. call nothing upon prompting. cotoms present at this time. cotom of (Occupational Speech Therapy) being cotoms and cotoms.				

Illinois Department of Public Health

STATE FORM 1YBN11 If continuation sheet 4 of 8

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		IL6014401	B. WING		05/21/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
	OF FDWADDOV#115	6277 CENT	ER GROVE RO	OAD		
LA BELLA OF EDWARDSVILLE EDWARDSV			VILLE, IL 620	25		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE	
S9999	Continued From page	e 4	S9999			
	No GI (Gastrointestin Abdomen is soft/norm signs or symptoms no symptoms noted. Nur	al) symptoms noted. nal. No GU (Genitourinary) oted. No endocrine sing interventions provided observed for changes in ctivity as allowed. to maintain correct				
	On 5/15/24 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."  On 5/15/24 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."					
	after dinner I went to broken hip, and she wentered the room, and she was gone. I thougwasn't 100% sure. No, the nurse didn't despoint click care or sure where else it is posted on the door. It Insurance Portability violation to post thing before she threw up.	vasn't doing great. So, I d took one look and knew ght she was hospice. So, I o ma'am we didn't start CPR. o CPR. It's (code status) on n the chart. I don't know for They don't have anything				

Illinois Department of Public Health

STATE FORM 1YBN11 If continuation sheet 5 of 8

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI COMPLE	
			A. BOILDING.			
		IL6014401	B. WING		05/2	1/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LA BELLA	OF EDWARDSVILLE		ER GROVE RO			
	OLIMAN DV OT		VILLE, IL 620			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
S9999	Continued From page	5	S9999			
	I didn't see her until after serving in the dining room, when I checked on her."  On 5/15/24 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 5/16/24 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 5/16/24 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. Onc the resident, they noti there is no POLST the	ee EMS comes and takes fy the doctor and family. If ey are automatically a full				
		a binder that lists code so find it on the EMR. rtified.				
	On 5/16/24 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					

Illinois Department of Public Health

STATE FORM 6899 1YBN11 If continuation sheet 6 of 8

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		11 504 4404	B. WING		0.5	104 10004
		IL6014401			0	5/21/2024
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I A REI I A	OF EDWARDSVILLE	6277 CEI	NTER GROVE RO	AD		
	COI EDWARDOVILLE	EDWARD	SVILLE, IL 6202	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From page	e 6	S9999			
		et the nurse find code status. d she would never				
	is an emergency she CPR certified and cou	M, V18, CNA, stated if there would tell her nurse. She is ald check code status in the her nurse to tell her the				
	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.  V23 CNA, stated she is CPR certified and if she found a resident unresponsive she would call for help.					
	-	is CPR certified and if she sponsive she would start d check status.				
		is CPR certified and if she sponsive I would check for a s and call for help.				
	dated 3/27/21 docum during routine care ar or annual assessmen significant changes in conditions, orientatior weights. Any resident life threatening, and the	n physical and mental n, change in vital signs, i's condition is considered to the resident requires are, notify the emergency				

Illinois Department of Public Health

STATE FORM 1YBN11 If continuation sheet 7 of 8

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY	
	IL6014401		B. WING		05	/21/2024
	ROVIDER OR SUPPLIER	6277 CENT	DRESS, CITY, STA FER GROVE ROSVILLE, IL 620	DAD		
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S9999	attempt of honor their hospitalization and er compliance with Adva The facility's policy er Resuscitation dated 2 individual ( resident, vi found unresponsive a licensed staff membe shall initiate CPR unle Not Resuscitate order CPR and or external cindividual. If The residence of the complex control of the control of the complex control of the control of	resident's wishes regarding nd of life issues. Maintain	\$9999			

Illinois Department of Public Health

STATE FORM 1YBN11 If continuation sheet 8 of 8