STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014401	A. BUILDING: _____ B. WING _____	C 11/21/2024

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LA BELLA OF EDWARDSVILLE	6277 CENTER GROVE ROAD EDWARDSVILLE, IL 62025

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S 000	Initial Comments Complaint Investigation 2449560/IL181332	S 000		
S9999	Final Observations Statement of Licensure Findings 300.3210t) Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These regulations were not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free from abuse for 1 of 3 residents (R2) reviewed for abuse in the sample of 3. This failure resulted in (R2) sustaining multiple bruises to her face requiring to be evaluated in the emergency room at the local hospital. This past non-compliance occurred on 10/31/2024 through 11/19/2024. R3's Face Sheet dated 11/4/2024, documents she was admitted to the facility on 1/16/2024 with diagnoses including Alzheimer's disease, anxiety, schizophrenia, depression and dementia. R3's Minimum Data Set (MDS) dated 10/7/2024, documents she is cognitively impaired with inattention and disorganized thinking. No indicators of psychosis. Behavioral symptoms not directed toward others.	S9999		

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R3's Care Plan, dated 10/31/2024 documents focus: resident at risk for abuse, abusing others demonstrates behaviors that have potential to disturb others. 10/31/2024 altercation with another resident in which (R3) was the perpetrator. Goal: resident will be free from abuse and without abuse behavior. Interventions: 10/31/2024 enhanced supervision 1:1, address resident concerns as they arise, observe for changes in customary routines. Resident moved to sitting room, 1;1 with nurse until EMS (emergency medical services) and police responding to transport resident to local hospital for psych evaluation.

R3's Progress Note, dated 10/31/2024 at 11:30 PM, documents there was screaming and yelling down the hall and the CNA (Certified Nurses Assistant) went down and noted it was coming out of res (resident) rm (room) and she was getting back in bed after attacking another res. Res stated that the other res was getting on her nerves. She stated that everything was building up so she got out of bed and started hitting res.

R3's Progress Note, dated 10/31/2024 at 11:38 PM, documents res stated that the other res was getting on her nerves and also stated that it kept building up then she got out of bed and started hitting her then went back to get in bed. Res was asked to come out of her rm to go sit in the tv rm and res refuse until this nurse went down to res rm and told her to come up to the tv rm. Res sat in the tv rm until EMS arrived. MD (physician), DON (Director of Nurses) and res family notified of incident.

R3's Petition for Involuntary/Judicial Admission, dated 10/31/2024 at 9:30 PM, documents res

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attacked another res. She has bruising on her hand and bruising to the other pt (patient) neck and face. (R3) stated she was getting on my nerves everything was building up and she got up and went over to the bed and started hitting the other res.
R3's Hospital Progress Note, dated 11/1/2024 documents a 71-year-old female with history of major neurocognitive disorder admitted 11/1/2024 through the local hospital emergency room after assaulting roommate at the nursing home. The patient has no memory of that.

R3 was readmitted to the facility per facility progress note, dated 11/6/2024.

On 11/20/2024 at 2:15 PM, R3 was observed laying in bed. (R3) smiled upon approach and when asked about the physical altercation between her and (R2) she stated she never hit anyone in her life and she would never ever do that because that's not the right thing to do.

R2's Face Sheet, dated 11/4/2024 documents hemiplegia and hemiparesis following cerebral infarction affecting right dominate side, facial weakness, cognitive communication deficit, dysphagia, expressive language disorder, frontal lobe and executive function deficit following other cerebrovascular disease, mixed receptive-expressive language disorder, pain and osteoarthritis.

R2's MDS, dated 9/10/2024, documents resident rarely/never understood, severely cognitively impaired with inattention and disorganized thinking, other behavioral symptoms not directed toward others occurred daily. Dependent with chair/bed-to-chair transfer, sit to lying, roll left and right, sit to stand. Incontinent of bowel and

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bladder.

R2's Late Entry Progress Note, dated 10/31/2024 at 10:00 PM, documents resident is alert and disorientated per usual baseline. Resident denies/exhibits no mental anguish or emotional upset. No new injuries noted on assessment. No pain. Reddish-purple bruising noted. Physician notified of change in condition and responsible party notified.

R2's Progress Note, dated 10/31/2024 at 11:54 PM, documents this res was assisted to bed and was not left in rm for about 15 to 20 min (minutes) before hearing screaming and yelling coming up the hall. CNA went down to see what was happening and she notice the other res was getting back in bed and she turned the light on and saw this res leg hanging to the side of the bed like she tried to get up and her face was scratched and bruised up then the CNA called for this nurse to come down to the rm. MD, DON and state representative for this res notified. Res was sent to local hospital to be assessed.

R2's Alleged Abuse Report, dated 10/31/2024 at 9:37 PM, documents incident description: there were screaming and yelling coming down the hall and a CNA went down to see what was going on and she noted that this residents legs was hanging out the bed like she wanted to get up and the other res was getting back in bed. This res face was scratched up and a black area under l (left) eye. Resident has aphasia but can explain what's going on and she showed that she hitting her in the face. Immediate action taken: staff stayed in rm for awhile and then the other res was sent to the tv rm until EMS came to take her to psych for evaluation. Level of pain: 4/10, breathing: normal, negative vocalization: none,

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facial expression: facial grimacing, body language: tensed, consolability: distracted. Injuries observed at time of incident: bruise on face.

R2's Hospital Paperwork, dated 10/31/2024, documents she was seen for injury due to physical assault: traumatic periorbital ecchymosis (bruising) of left eye and nose.

R2's Progress Note, dated 11/1/2024 at 4:35 AM, documents resident returns to facility via EMS, MD notified.

R2's New Identified Skin Condition Form, dated 11/4/2024, documents face - bruising to left eye, nose, left chin, right forehead and right bottom eyelid.

On 11/20/2024 at 1:52 PM R2 sat up in a wheelchair in the dining room. Upon approach R2 smiled but didn't respond to IDPH (Illinois Department of Public Health) surveyor's questions regarding the physical altercation between her and R3. R2 had light purple/pink bruising under her left eye at the time of the interview.

On 11/20/2024 at 3:07 PM V9, LPN (Licensed Practical Nurse) stated she worked the night of 10/31/2024 and responded to the physical altercation between R2 and R3. R2 doesn't communicate verbally due to post stroke. Prior to the incident R2 was up in the dining room. R3 communicates verbally and is ambulatory and was in bed when staff assisted R2 to bed. A few minutes later I heard screaming and told staff to go down the hall and see what was occurring. R3 was getting back into bed and noted R2's legs were off the side of the bed as if she was trying to

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get up. Staff turned the light on and saw R2's face was "bruised up". Staff called for V9 to come to the room. She observed R2's face bruised and had a sad face and R2 is always happy so she knew R2 was affected by what occurred. R3 was asked why she hit R2 and R3 responded, "She was getting on my nerves." R3 didn't respond to V9's additional questions. V9 assessed R2 at that time. Staff stayed in the resident's room. V10 (former DON) and V1 (administrator) were contacted. R3 was moved to the sitting area across the nurse's station and R2 was sent to the hospital for further evaluation and treatment due to the facial bruising. R3 was sent to the hospital for a psychiatric evaluation.

On 11/21/2024 at 10:30 AM V11, CNA stated she worked 10/31/2024 2:00 PM - 6:00 AM but was not assigned to R2 and R3, she was assigned to another hall but she heard yelling so she went to the room and when she entered the room she turned the light on and noted R3 was getting back in bed and (R2) was in bed with her legs off the side of the bed which was odd because (R2) is a total lift, she doesn't get out of bed by herself or walk and she immediately noted bruising to (R2's) left eye. (R2) can't verbally communicate but V11 asked her if her roommate, (R3) hit her and (R2) pointed to (R3) yelled and shook her head yes.

On 11/21/2024 at 10:50 AM V12, LPN stated she worked night shift on 10/31/2024 and arrived at the facility at around 10:00 PM. The resident to resident altercation occurred between (R2) and (R3) right before she got there. She assisted nursing staff and assessed (R2) when she got to the facility and assessed (R2). R2 was crying and when she asked her if she was in pain (R2) nodded her head, yes. (R2) Sustained bruising to her face from her roommate, (R3) hitting her. V12

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also assessed (R3) who was in another room and assessed her to have red and swollen hands at that time. V12 asked (R3) why she hit (R2) and she stated, "She deserved it." (R3) was also very agitated and called (R3) a w**** and stated she stole her stuff.

On 11/21/2024 at 11:05 AM V13, CNA stated she worked day shift 2:00 PM - 10:00 PM on 10/31/2024. Toward the end of (V13) shift her and V11 were sitting at the nurse's station charting and they heard screaming from the 100 hall. They went to see what was going on and observed (R3) getting back into bed and saw (R2's) legs were off the side of the bed which is abnormal for her because she is a one staff assist lift to get out of bed and she doesn't communicate verbally. V11 asked (R2) if (R3) hit her and (R2) pointed at (R3) and shook her head yes. V13 stated she wasn't assigned to (R2) or (R3) and she didn't assist (R2) to bed that night. V13 stated the nurse came to assess both residents and she left the facility shortly after.

On 11/21/2024 at 12:30 PM V14, CNA stated she was assigned to (R2) and (R3) on 10/31/2024 she worked evening shift from 2:00 PM - 10:00 PM. V14 stated (R3) ambulates throughout the facility and has no aggressive behaviors toward other residents, (R3) participated in Halloween activities that day and she was her usual chipper self. (R2) is a total care resident and a sit to stand lift to transfer from wheelchair to bed. V14 stated she worked with V15, CNA and they swapped residents to lay down so V15 assisted (R2) to bed that night. V14 observed the nurse running down 100 hall so she responded to (R2) and (R3's) room and noted (R2) had a bruised face and looked beat up. At that time (R3) was calling (R2) a w****.

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S9999	Continued From page 7 On 11/20/2024 at 1:45 PM V7, CNA stated roommate (R3) hit R2 on the face a few weeks ago and (R2's) face was all bruised up. R2 is total care resident and requires a sit to stand lift to transfer to and from bed. R2 can't defend herself because she is post stroke and she is unable to communicate verbally. V7 stated she wasn't here when the physical altercation took place but she observed R2 the next day and she looked all black and blue on her face like R3 must have jumped her or something. On 11/20/2024 at 2:00 PM A V8, Social Services Director (SSD) stated she received a call from facility staff on 10/31/2024 at 10:18 PM and staff reported that R3 hit R2 on the face and they were both being sent to the hospital. R3 for a psychiatric evaluation and R2 due to the extent of the injuries she sustained from R3 hitting her on the face multiple times. R3 was admitted to the facility 1/2024, she is pleasant and ambulates throughout the facility and had no behaviors at all until that day. V8 recalled observing R3 up in the dining room participating in Halloween activities that day and there were no signs of upcoming behaviors at that time. On 11/20/2024 at 2:30 PM V1, Administrator stated R3 has a psychiatric diagnosis and has had no bad behaviors since being admitted to the facility. V1 observed R3 participate in Halloween activities in the dining room the day of the incident and there were no signs that anything was off about her that day. V1 stated no other abuse allegation within the last 90 days. Prior to the survey date, the Facility took the following actions to correct the noncompliance on 11/19/2024.	S9999		

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S9999	Continued From page 8 Immediate Actions: 1-R1 was assessed, plan of care reviewed and updated. R2 was sent to the hospital for evaluation and treatment of acute psychotic state. 2-Admistrator, Director of Nursing, Assistant Director of Nursing, Staffing Coordinator, Evening Receptionist and a unit manager in-serviced nursing and therapy staff regarding the facility's abuse policy with emphasis on how to prevent abuse. 3-Administrator immediately initiated ongoing audits of abuse immediately addressed upon identification and/or re-education conducted weekly for 4 weeks. After 4 weeks, the audits will be completed monthly for a minimum of 3 months. 4-Any concerns identified from the audits will be addressed immediately and will be reviewed by QAPI team monthly, to determine if current interventions are adequate or additional actions need to be completed to ensure compliance. Ongoing Actions: 1-Education will be provided to new employees prior to being allowed to work in the Facility and all employees at the monthly inservice. 2-Concerns will be addressed immediately and discussed during the monthly QAPI Committee for resolution.	S9999		

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