Illinois Department of Public Health

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 **02/01/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA BELLA OF EDWARDSVILLE	**6277 CENTER GROVE ROAD** **EDWARDSVILLE, IL 62025**

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S 000	Initial Comments	S 000		

Complaint #2440838/IL169315

S9999	Final Observations	S9999		

Statement of Licensure Violations

300.610a)
300.1210a)
300.1210b)
300.1210c)
300.1210d)6)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a

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comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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These Requirements were not met evidenced by:

Based on observation, interview and record review the facility failed to ensure safe transfers for 1 of 3 residents (R2) reviewed for transfers, in the sample of 12. This failure resulted in R2 being transferred incorrectly and resulted in severe bruising on her body covering her right shoulder from the back and underneath side and her entire chest which resulted in her being hospitalized.

Findings include:

R2's Physician Order Sheet (POS), dated January 2024, documented diagnoses of Atherosclerotic heart disease, hyperlipidemia, hypertension, abnormal finding of lung field, osteoarthritis, diverticulosis, disorder of thyroid, dysphagia, abnormal levels of serum enzymes, complete intestinal obstruction, acute kidney failure, and personal history of (healed) traumatic fracture. R2's POS also documented that she was taking 81 milligrams (mg) of aspirin once a day.

R2's Minimum Data Set (MDS), dated 1/6/2024, documented that R2 was severely impaired for cognition. It also documented that they needed assist for sit to stand, transfer chair to bed, toilet transfer, tub/shower transfer. It also documented, "Dependent: Helper does all the effort, Resident does none of the effort to complete the activity or the assistance of two plus helpers (staff) are required for the resident to complete the activity." The MDS also documented that R2 uses a wheelchair and has no impairment on the upper or lower extremities.

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R2's Care Plan, dated 1/18/2024, documented, "(R2) has an ADL self-care performance deficit related to confusion. (R2) is a minimum assist of 1 staff for bed mobility and assist of two staff with sit to stand. (R2) has an ADL (activities of daily living) self-care performance related confusion."

R2's Progress Notes, dated 1/29/2024 at 7:53 AM, documented, "Hospitalized/bruising."

R2's Initial Report, dated 1/27/2024 documented, "(R2) has bruising of unknown origin in the abdominal region possibly caused by a gait belt. (R2) takes blood thinners. (R2) has not exhibited any loss of range of motion. MD (Medical Doctor) and family notified. Resident sent to hospital for further evaluation. Abuse not suspected at this time. Full evaluation and investigation to follow."

On 1/30/2024 at 2:12 PM, R2's bruising started from over her right shoulder, approximately a foot wide, purple in color and extended underneath her arm (approximately five inches in width) on her right arm. The bruising was present from R2's right arm both behind and extended to the front of the shoulder, approximately 5 inches in width. From the front the area went from the top of the right shoulder area and extended to the entire chest area all the way across the chest to the left side. On the right side just above the breast area there was large baseball size swelling underneath the skin (hematoma). R2 grimaced when she was transferred and grabbed her left side and stated she did not know what she did, but the area hurt. Resident was asked what had happened and stated, "How the he** would I know." There was no bleeding present.

V6's, Certified Nursing Assistant (CNA), witness statement, dated 1/30/2024, documented, "This

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writer (V2, Director of Nursing) spoke with (V6) on Saturday 1/27/2024. She stated that she transferred resident from bed to wheelchair after breakfast using gait belt. She then transferred resident again after lunch to toilet using a gait belt. Staff members commented that resident appears to be requiring more assistance, support with transfers as of recently. This writer asked CNA if she noted any grimacing or flinching when providing care or during transfers. (V6) stated that she feels the sit to stand would not be safe and feels that a mechanical lift would be more appropriate."

On 1/30/2024 at 1:03 PM, V6, CNA, stated, "Saturday morning I came in to work and when I came in (V10, Licensed Practical Nurse (LPN) and (V11, LPN) were working from the night shift and I asked them if they needed any help and they told me (R2) and her roommate (R6) still needed checked on. So, I went to help and change (R2) and (R6). I changed (R6) first because she is a (mechanical lift) and I got help with her. Then afterwards I went to change (R2). (R2) can roll and help out a little during a transfer. I put a gait belt on her and did a stand pivot with the gait belt. I did not have another staff member in the room with me. I did not use the sit to stand for the transfer. If you look on the computer (R2) it says (R2) is a sit to stand with 2 staff. (R2) is not able to hold on with her hands and I felt that it was safer to do the pivot with the gait belt versus the sit to stand. I do not believe it was me that gave her the bruises. I can only say I did not have assistance with (R2's) transfer and I do not feel that I gave her the bruises, but I did not transfer her with another staff member."

On 2/1/2024 at 1:23 PM, V8, Registered Nurse (RN) stated, "I was called into the room by a CNA

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(V6) and the CNA was changing (R2) and getting her ready for bed and she called me in because there was some bruising on her. I assessed her and she had extensive bruising, and I called the physician and had her sent out. I did not measure the bruising. The bruising was down her right side, on her ribs, a large hematoma above her chest. I am not aware of any falls prior or why she would have the bruising like she did, so I sent her out."

On 2/1/2024 at 4:52 PM, V9, LPN, "I was passing meds on 200 hall, (V8, RN) came and got me and said hey, I need you to witness something with me. I followed her to (R2's) room. (R2) was in the bed leaning on left side in bed and she had a lot of bruising from her mid shoulder area and the bruising went all the way across her entire chest. I did not see any visible bleeding, it was not dark in color and some small darker areas it was faint, it looked like a new bruise as there were no yellow or green colors in the bruise. It covered a very large area, and it surprised me because there was so much bruising from her shoulder to across her entire chest. I was not aware of her having any fall or injuries previously and (V8) sent her out. No measurements were taken but it was extensive bruising and covered her entire chest area."

V7's, CNA, witness statement, undated, documented, "I went to change (R2) into a gown and put her to bed at around 7:45 AM or 7:30 AM and I noticed she was all bruised up and when I took her shirt off while she was laying in the bed I told the nurse to come and look at her and asked if she knew she had bruises on her."

On 1/30/2024 at 11:52 AM, V2, Director of Nursing stated, "I reviewed (R2's) chart and (R2)

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was a sit to stand with two staff assist for transfers. I am not sure why (V6) was the only staff member that transferred (R2) and I am not sure why (V6) did not have another staff member assisting when transferring (R2). I would have expected (V6) to get another staff member when transferring (R2). I am not sure why she did not know (R2) required two staff members or why she transferred her by herself."

R2's Hospital Records, dated 1/28/2024 at 12:43 PM, documented, "Patient was brought from nursing home for evaluation of bruising noticed today. Nursing home facility is unable to give details about this bruising, it was between yesterday and today that she developed bruising on the anterior chest and the right upper extremity, denied fall or trauma, patient is not on blood thinner, does not have recurrent bruising in the past. She was evaluated in the ER (emergency room) and there was no finding of fracture or dislocation, she has leukocytosis and urine sample has not been obtained in the ED (emergency department). Due to the findings of bruising with no explanation, patient is considered not safe to discharge back to same facility at this time and she will be admitted for observation. Hematoma present right anterior shoulder and bruising down left underarm. Exam: Chest wall: Bruising and ecchymosis on the entire anterior chest wall, hematoma on the right anterior chest, tender, no crepitus. Extremities: Bruising and ecchymosis on the right upper extremity involving the right axilla as well, lower extremity contacted."

On 2/1/2024 at 4:48 PM, V1, Administrator stated we expect staff to follow the Care Plan for patient care. I do not have a policy for transfers."

The Facility Fall Policy with a revision date of

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	3/27/2021 documents, "It will be the standard of this facility to complete an initial assessment, on-going monitoring/evaluation of resident condition and subsequent intervention development in an attempt to prevent falls and injuries related to falls."			
	(B)			