STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145753	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Bella of Danville	1701 North Bowman Danville, IL 61832

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to ensure medications were available to be given as ordered resulting in multiple missed doses of medications for three (R5, R6, R7) of six residents reviewed for medications in the sample list of 12. Findings include: 1.) On 10/24/24 at 12:13 PM R6 stated the facility has run out of R6's medications but was unable to state which medications. R6's Minimum Data Set (MDS) dated [DATE] documents R6 is cognitively intact. R6's August, September and October 2024 Medication Administration Records (MARs) document to give Duloxetine Hydrochloride (antidepressant) Delayed Release 60 milligrams (mg) by mouth one daily and Lorazepam (antianxiety) 0.5 mg twice daily. Duloxetine was not administered on 8/28/24, 9/12/24, 9/27/24, and 10/21/24. Lorazepam was not administered as ordered on 9/21/24, 9/23/24-10/3/24. R6's Nursing Notes document the following: On 8/28/2024 at 5:49 PM Duloxetine was unavailable. On 9/12/2024 at 4:36 PM Duloxetine was on order and awaiting pharmacy delivery. On 9/21/24 at 9:24 AM Lorazepam was on order. On 9/23/2024 at 10:50 AM the Nurse Practitioner said R6 is now seen by (Psychiatry Services), who should oversee ordering of Lorazepam. On 9/26/24 at 8:53 PM Lorazepam was on order. On 9/27/24 at 4:29 PM Duloxetine was on order. On 9/27/24 at 8:57 PM waiting for pharmacy to deliver Lorazepam. On 9/29/2024 at 8:57 AM and 10:33 PM unable to obtain new Lorazepam script. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/2024 at 9:28 AM Lorazepam was not available. On 10/1/2024 at 7:45 PM Lorazepam was not available. On 10/1/2024 at 8:04 AM Lorazepam was on order. On 10/2/2024 at 10:40 AM getting new Lorazepam order from doctor. On 10/21/2024 at 3:46 PM R6's Duloxetine was on order. There is no documentation in R6's medical record that R6's physician was notified of the missed doses of medications. The facility's backup medication box Inventory Replenishment Report dated 3/21/23 includes Lorazepam 0.5 mg. 2.) On 10/24/24 at 10:55 AM R7 stated the facility ran out of R7's bone medication for several weeks. R7's MDS dated [DATE] documents R7 as cognitively intact. R7's September and October 2024 MAR documents Alendronate-Cholecalciferol 70-2800 mg give one tablet by mouth once weekly on Fridays for Osteoporosis ordered 5/3/24-10/17/24, and this medication was not given as scheduled between 9/1/24 and 10/17/24. The order was changed on 10/18/24 to Alendronate Sodium 70 mg weekly on Fridays. R7's Nursing Notes document the following: On 8/30/24 at 5:18 AM Alendronate-Cholecalciferol was on order. On 8/30/2024 at 11:14 AM Alendronate was not refilled due to a billing issue and the billing department was notified. On 8/31/24 at 2:18 AM Alendronate was not refilled due to a billing issue, the billing department was notified and awaiting a prior authorization for refill. Will follow up with the provider in the morning. On 9/13/24 at 5:57 AM Alendronate was not available. On 9/13/2024 at 7:11 AM called the pharmacy regarding Alendronate refill, but unable to reach a representative. On 9/27/24 at 4:36 AM Alendronate on order. On 9/30/2024 at 6:46 AM the pharmacy was called regarding Alendronate, unable to reach a representative. The on-call nurse was notified. On 10/6/24 at 6:06 AM prior authorization is the documented reason why Alendronate was not given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/11/24 at 4:52 AM Alendronate was on order. On 10/16/2024 at 6:18 PM pharmacy was contacted to reorder Alendronate; medication was transferred to billing department due to being a non-covered medication. There is no documentation in R7's medical record that R7's physician was notified of the missed doses and non-coverage of Alendronate prior to 10/18/24. 3.) R5's October 2024 MAR documents to give Aripiprazole (antipsychotic) 2 milligrams (mg) by mouth daily. On 10/24/24 at 10:02 AM V9 Licensed Practical Nurse administered R5's morning medications. V9 was unable to locate R5's Aripiprazole 2 mg tablets and therefor did not administer this medication. At 11:55 AM V9 stated V9 was unable to locate this medication and there was none in the facility's backup supply box. V9 stated V9 will have to reorder the medication from the pharmacy. V9 looked in R5's electronic medical record and submitted a reorder to the pharmacy for this medication. V9 stated the system shows this medication was last reordered on 9/26/24. R5's Nursing Note dated 10/24/2024 at 11:58 AM documents Aripiprazole was not administered due to the medication being unavailable. There is no documentation of any follow up with pharmacy or the physician regarding this medication being unavailable. On 10/24/24 at 12:44 PM V2 Director of Nursing stated if medications are not available to be given then it is documented on the MAR and a progress note should document the pharmacy was notified or if an insurance issue. V2 confirmed a checkmark on the MAR indicates the medication was given. V2 stated if a medication is not given the nurse should document the reason. At 12:50 PM V2 stated the physician was contacted on 10/17/24 and gave orders to change Alendronate to an alternate covered medication. V2 confirmed R7's missed doses of this medication due to an insurance non-coverage issue. At 2:08 PM V2 stated the pharmacies sends an electronic facsimile notification to the facility for insurance non-coverage issues, we are to follow up with the physician to notify of the non-coverage and obtain orders. V2 stated V2 was not aware of R7's Alendronate non-coverage until September. V2 completed the required form and submitted the form to the pharmacy. V2 stated if a medication is not available and doses are missed, the physician should be notified to obtain a hold order. V2 stated if the medication is not available in the backup medication supply box, then our pharmacy works with a local pharmacy to deliver medications that are needed prior to the scheduled daily delivery. V2 confirmed the nurses must contact the facility's pharmacy to initiate this process if needed. The facility's pharmacy policy Unavailable Medications dated 10/25/14 documents medications may be unavailable from the pharmacy due to drug recalls, temporary shortage, or permanent drug recalls. This policy documents the pharmacy suggests alternative/comparable drugs and dosages, and the nursing staff are responsible for notifying the physician or the facility's medical director to explain the situation and obtain new orders. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's pharmacy policy Emergency Pharmacy Service and Emergency Kits dated 7/18/18 documents the emergency pharmacy is available 24 hours per day and emergency needs are met by using the facility's emergency medication box or by special order through the pharmacy. This policy documents when a medication is not readily available the nurse should contact the physician to determine if it can be delayed until the scheduled pharmacy delivery. The nurse should then check the backup supply box and if the medication is unavailable the nurse should contact the after-hours emergency pharmacy number. This policy documents if the medication is a controlled medication, the nurse will contact the pharmacist to receive a one-time access code to access the controlled substances stored in the emergency box. Emergency medication administration is documented on the resident's MAR.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 40385 Based on observation, interview, and record review the facility failed to administer medications as ordered for three (R4, R7, R5) of seven residents reviewed for medication administration in the sample list of 12. This failure resulted in three medication errors out of 25 opportunities, a 12 % medication error rate. Findings include: 1. R7's October 2024 Medication Administration Record (MAR) documents to administer Ferrous Sulfate 325 milligrams (mg) one tablet by mouth once daily scheduled as Lib B (Liberalized Breakfast). On 10/24/24 at 9:46 AM V9 Licensed Practical Nurse administered R7's morning medications Aspirin 81 milligrams (mg), Folic Acid 1 mg, Calcium Carbonate 600 mg, Vitamin D 1000 units. V9 had to locate a bottle of Thiamine 100 mg and administered one tablet at 10:10 AM. V9 did not administer Ferrous Sulfate 325 mg. At this time V9 confirmed R9's morning/breakfast medication administration was complete. At 10:13 AM V9 confirmed V9 had not administered R7's Ferrous Sulfate 325 mg. The facility's Med (Medication) Pass Times documents Liberalized Breakfast is scheduled to be given between 6:00 AM and 11:00 AM. 2.) R4's October 2024 MAR documents to administer Combivent Respimat inhaler 20-100 mcg/act (micrograms per actuation) one puff three times daily and administer Breo Ellipta inhaler 100-25 mcg/act one puff once daily, swish and spit after each inhalation. The Breo Ellipta Highlights of Prescribing Information dated January 2019 documents to rinse your mouth after inhalation administration. On 10/24/24 at 9:56 AM V9 obtained Breo Ellipta 200-25 mcg/act (per actuation), which was labeled with R12's first name. V9 also obtained Combivent Respimat inhaler 20-100 mcg/act labeled with R12's full name. Both inhalers were stored in the original packaging container that was labeled with R4's name. V9 handed the Breo Ellipta to R4, and R4 self-administered one puff. R4 did not rinse his mouth after administration. V9 left the room and did not instruct R4 to rinse his mouth after administration. On 10/24/24 at 10:19 AM V9 confirmed the Breo Ellipta and Combivent inhalers labeled with R12's name was in R4's original packaging for R4's inhalers. V9 confirmed R12's Breo Ellipta dosage is not the same dose as R4's, and the incorrect dose of medication was given. V9 stated V9 did not understand why R12's medications were in the same medication cart as R4's since they don't reside on the same hall of the facility. V9 confirmed V9 did not instruct R4 to rinse and spit after R4's inhaler administration. V9 stated R4 usually does that himself. R12's Physician Order dated 6/29/24 documents to administer one puff Breo Ellipta 200-25 mcg/act once daily. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 12:44 PM V2 Director of Nursing stated V2 was just made aware that R12's inhalers were stored in R4's inhaler container. V2 stated inhalers should be stored in the correct resident's medication packaging container. V2 stated V2 thinks a nurse was working two different medication carts and may have put R12's inhaler in the wrong cart by mistake. 3.) R5's October 2024 MAR documents to give Aripiprazole (antipsychotic) 2 mg by mouth daily. On 10/24/24 at 10:02 AM V9 administered R5's morning medications. V9 was unable to locate R5's Aripiprazole and therefor did not administer this medication. At 11:55AM V9 stated V9 was unable to locate this medication and there was none in the facility's backup supply box. V9 stated V9 will have to reorder the medication from the pharmacy. V9 looked in R5's electronic medical record and submitted a reorder to the pharmacy for this medication. V9 stated the system shows this medication was last reordered on 9/26/24. R5's Nursing Note dated 10/24/2024 at 11:58 AM documents Aripiprazole was not administered due to the medication being unavailable. There is no documentation this medication was given on 10/24/24 or that the physician was notified of the missed dose. The facility's Administering Medications policy dated April 2019 documents medications are to be administered according to physician orders, and check to verify the right resident, right medication, right dosage, right time, and right method prior to administering the medication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to administer insulin timely resulting in repeated significant medication errors for one (R6) of six residents reviewed for medications in the sample of 12. Findings include: On 10/24/24 at 12:13 PM R6 stated R6 has not been getting her medications on time, and some medications that are scheduled to be given at noon are not given until later in the afternoon. R6 stated this includes insulin and R6's blood sugars have dropped because of it. R6's Minimum Data Set, dated dated dated [DATE] documents R6 is cognitively intact. R6's October 2024 Medication Administration Record (MAR) documents to administer Lispro (insulin) 36 units and additional dosing per blood glucose based sliding scale before meals three times daily at 7:30 AM, 11:00 AM, and 4:00 PM. R6's October 2024 Medication Administration Audit Report documents the following: Lispro scheduled at 7:30 AM was given on 10/6/24 at 1:30 PM, 10/9/24 at 9:23 AM, 10/16/24 at 9:01 AM, and 10/20/24 at 10:04 AM. Lispro scheduled at 11:00 AM was given on 10/3/24 at 1:56 PM, 10/6/24 at 1:30 PM, 10/11/24 at 4:17 PM, and 10/15/24 at 2:18 PM. Lispro scheduled at 4:00 PM was given on 10/3/24 at 5:35 PM, 10/4/24 at 5:45 PM, 10/7/24 at 5:36 PM, 10/11/24 at 5:50 PM, 10/12/23 at 5:52 PM, 10/16/24 at 7:39 PM, 10/18/24 at 6:06 PM, 10/20/24 at 6:56 PM, and 10/22/24 at 5:39 PM. On 10/24/24 at 1:40 PM V2 Director of Nursing confirmed the nurses document medication administration times at the time the medications are given, and the recorded times should be accurate. At 2:08 PM V2 stated if the medication has a scheduled time (not liberalized range), then the medication should be given within an hour window before or after the scheduled time. The facility's Administering Medications policy dated April 2019 documents medications should be administered according to physician's orders and within one hour of the prescribed time, unless otherwise specified.