

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER LA Bella of Danville		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642</p> <p>Based on observation, interview, and record review the facility failed to provide adequate supervision for a cognitively impaired resident, known to exit seek, and with a prior elopement history, to prevent an elopement. The facility also failed to complete a full body post-elopement assessment to determine injury, failed to develop an elopement care plan with interventions in a timely manner, and failed to ensure functional exit door alarms. These failures resulted in R1, a severely cognitively impaired resident at risk of falls and receiving anticoagulation therapy, exiting the facility without staff knowledge or supervision, walking approximately 0.4 miles in extreme cold weather down a busy street. R1's likely path included steep ditches and large rocks. These failures affect one of three residents (R1) reviewed for elopement on the sample list of 14.</p> <p>The Immediate Jeopardy began on 01/01/25 at approximately 4:30 PM, when R1 exited the facility by a deactivated alarmed exit door. Staff were unaware R1 was missing for approximately one-half to one hour. During this time R1 walked in the street during rush hour traffic, in below freezing temperature, without a coat until a passerby alerted the facility staff of R1's location. Staff confirmed R1 was not assessed for possible injury, or hypothermia after being brought back to the facility. V1 Administrator was notified of the Immediate Jeopardy on 1/16/25 at 3:00 pm.</p> <p>The surveyor confirmed by observation, interview and record review the Immediate Jeopardy was removed on 01/23/25, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.</p> <p>Findings include:</p> <p>R1's Census record documents R1's initial admission to the facility was on 12/27/24.</p> <p>R1's Diagnoses sheet dated 12/27/24 documents the following: Dementia in Other Diseases Classified Elsewhere, Severe, With Mood Disturbance, Delirium Due to Known Physiological Condition, Restlessness and Agitation, Hypertension, Paroxysmal Atrial Fibrillation, Muscle Weakness (Generalized), Unspecified Abnormalities of Gait and Mobility, and Other Lack of Coordination.</p> <p>R1's Physician Order Sheet (POS) dated 12/27/24 - 1/9/25 documents the following: Eliquis (anticoagulant) Oral Tablet 5 (five) milligram (mg), Give 5 mg by mouth two times a day for Atrial Fibrillation, Metoprolol Succinate ER, Oral Tablet Extended Release 24 Hour, 50 MG every day for Hypertension and Spironolactone Tablet 25 MG, Give 1 tablet by mouth one time a day for Hypertension.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's Minimum Data Set (MDS) dated [DATE] documents R1 is severely cognitively impaired and R1 has a history of falls before and after admitting to the facility.</p> <p>R1's Admission Assessment (Baseline Care Plan) dated 12/27/24 documents R1 has had falls prior to admission, R1 has an unsteady gait and sitting balance, and R1 is at high risk of falls.</p> <p>R1's Elopement Evaluation dated 12/30/24 documents R1 that has the ability to leave the building, R1 is not considered independent for outside pass privileges, and R1 has been noted at exit doors or wandering. R1's Care Plan was not updated to include a concern for elopement until 1/1/24.</p> <p>R1's Nurse's Note dated 12/30/2024 at 04:13 am documents, Resident still up and not staying seated. Resident wandering and exit seeking. Resident pushing on exit doors. Redirected but continues.</p> <p>R1's 72 hour Charting Follow-Up Late Entry Note dated 1/1/25 at 10:42 AM (fall 12/30/25) documents (R1) Follow-up assessment post-fall. Resident is alert and disoriented per usual baseline. No new injuries noted on assessment. No pain. No changes noted in ROM (range of motion). Bed in lowest position. Monitoring for behaviors. Call light in reach. Non-skid socks/ footwear in place, increase monitoring, (departure alert device), and 1:1 (one on one). No skin issues noted. No bruising noted. No s/s (signs or symptoms) of infection noted to site. No swelling noted. Fall Follow up assessment post-fall.</p> <p>R1's Nurses Notes dated 12/30/24 at 11:40 pm document, Resident alert but confuse(d) and disoriented. Respiration even and non-labored. Speech clear. Appetite good and drink fluids well. Needs assist with ADLs (Activities of Daily Living). Can be combative when agitated. Uses wheelchair for mobility. No complaints made from fall. Continue(s) to get out of bed or chair by himself and at times cannot be dissuade. Very unstable when on his feet. High risk for falls. Concern for a need for one on one monitoring made known to DON (V2, Director of Nursing) and Administrator (V1).</p> <p>R1's Behavior Note dated 12/31/2024 at 12:21 am documents, Resident noted to be combative and aggressive with CNA (unidentified Certified Nursing Assistant) when attempting to assist resident. Resident grabbed CNA in collar while she was attempting to help resident back in his wheelchair. Shortly after resident attempted to elope via south hall exit. Resident was able to open the door and step outside before the nurse (unidentified) on duty was able to catch him. Resident began to resist staff attempting to re-direct him from the exit. Resident ask this writer if she had called the police for him, he was being held against his will and needed the police to rescue him. Resident was informed he was placed in the facility for assistance with his care by his family and he was not being held hostage but receiving health care. Resident was assisted back to the nursing station where he is currently sitting.</p> <p>R1's Admission assessment dated [DATE], signed by V3, Nurse Practitioner documents R1 has a baseline altered mental status and is non decisional and R1 had a fall over the weekend without any noted injury. V3's Assessment documents, (R1) has a history of impulsivity since admission (12/27/24) to the facility, crawling in his room, and requiring frequent observation with fall mats at bedside. He has also been wandering and exit-seeking, with potential placement on a (departure alert device bracelet) per (V2, Director of Nursing) DON and clinical staff. The same assessment directs staff to provide Frequent observation.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 1/9/25 at 7:15 am V8, Registered Nurse (RN) stated, The evening (R1) got out and walked down (Street Name) Avenue, I think it was the 01/01/25. A passerby called the facility and said we had a confused resident walking in the middle of the street, over by the apartments. The passerby said he (R1) did not have on a coat. It was pretty cold day. I can't remember if it snowed yet, but I think it may have. There was snow when I left my shift. (Street Name) Avenue traffic gets very busy during evening rush hour. The CNA (V15, Certified Nursing Assistant) went right away to go find him (R1). (R1) was always trying to go somewhere. He was consistently exit-seeking. He would shake the exit doors whenever I worked. He had never gotten far out of the building when I had him (was R1's nurse). I had not seen (R1) for a quite a while that evening. I am not sure how long he was gone. Nobody had seen him for about an hour. I asked everyone. I figured it was probably (R1) the passerby saw. None of us working heard an alarm go off. We had no idea how he got out of the building, or how long he had been gone. I ended up telling (V12, Maintenance Director) to look at the cameras to find out which door (R1) went out because nothing triggered an alarm when he (R1) left. I admitted (12/27/24) him (R1) and did not know he was an elopement risk at time. He was admitted with A-Fib (abnormal fast heartbeat) and had a history of falls. It was evident within a day or two of admission he was an elopement risk. He was not a one-on-one until 1/1/25 after he was found outside walking in the street. We put a (departure alert device) on him at time too. When (V15, CNA) brought him (R1) back to the facility, he (V15, CNA) said he did not see any injuries. (V15, CNA) said (R1) was very cold and warmed up in (V15, CNA's) car. V8, RN stated I did not complete a full body assessment, vital signs or neurological assessment when (R1) returned to the building. I did not complete an accident report, or risk management report. The incident note you have is all I had time to do. I was working a hall and a half (of residents) and training a new nurse. Now I think about it, he (R1) had several falls in the facility. He came to us with a history of falls. He could have had a fall outside when he eloped evening (1/1/25). He used a wheelchair, and we were constantly reminding him not to stand up. He had a very unstable gait. I should have completed a thorough assessment, just like we do when a resident has an unwitnessed fall.</p> <p>On 1/9/25 at 8:55 am V13, R1's Family Member stated, (The facility) has called me (V13) four times about (R1) exiting the building. Three times, I was told he was just outside the doors. Once he walked right out the front door. The other times he went out the side doors. One time they reported he was found walking down (Street Name) Avenue. I was not thrilled about. It was 20 degrees (Fahrenheit) outside. I did not understand how could happen if he was adequately supervised. He can't walk steady and is in a wheelchair. How could he get all the way to (Street Name) Avenue and have been walking. He has had a couple falls before and after being at (the facility) trying to walk.</p> <p>On 01/9/25 at 4:45 pm R6 stated R6's room and R1's room, share a bathroom. R6 stated R1 was confused and repeatedly came in to R6's room and yelled for R6 to get out of R1's house. Staff were supposed to be watching him. Half the time the staff were visiting with each other down the hall, nowhere near his (R1) room. I saw with my own eyes several times. They did nothing to keep him out of my room. I finally put a chair against the bathroom door so he would stop coming in. He was supposed to have a sitter with him all the time. They obviously were not keeping a good eye on him.</p> <p>(continued on next page)</p>		

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One single-wide gate was to the left, down a sidewalk off the patio approximately 50 feet. A double-wide second gate was straight ahead off the patio, approximately 50 feet. V15 stated the single-wide gate was likely not the gate R1 used, because it opens inward and would be difficult to maneuver R1's wheelchair. V15, CNA and this surveyor walked the approximately 50 feet forward to a double-wide gate, which opens outward. The patio gate has an emergency exit required pushing the button and holding it. No alarm sounded. Together V15 and this surveyor walked approximately 150 feet around the fenced patio to winding sidewalk. The sidewalk sloped downward past two wings of the facility building, as we headed towards the front of the building on the south side. V15, CNA stopped at the edge of the building outside the therapy room. V15, CNA stated, This is where (R1's) left his wheelchair that night. V15 stated, In order for (R1) to get to (Street Name) Avenue he would have had to walk from his wheelchair across all this grass and head north again to where I found him. V15, CNA and this surveyor walked down a 50-foot uneven hill, from the sidewalk where R1's wheelchair had been found. At the base of the uneven hill, we continued to walk through the grass another approximately 150 feet straight towards (Street Name) Avenue. The ground was rough with divots throughout. V15, CNA and this surveyor were approximately 10 feet from the street. There were approximately over one hundred, extra-large scattered rocks stacked haphazardly from the ground. The large rocks extended up an eight-foot steep incline. At the ground level the extra-large rocks spanned six feet wide at the base and extended upward to a three-foot-wide easement at the street. V15, CNA stated each rock weighed approximately 20 or 25 pounds. The street curb, on each side of the three-foot-wide easement, was eight inches tall. As this surveyor and V15, CNA decided we could not safely balance ourselves on the rocks, we turned to walk in the uneven grass, at the bottom of the eight-foot steep incline. V15 stated, (R1) may have climbed the rocks, but most likely walked in the grass. He (R1) had a very unstable gait. That is why he used a wheelchair. He had a couple falls in the facility from trying to stand up from his wheelchair. He was not safe to walk on his own. I can't imagine how (R1) was able to walk this area. You (surveyor) and I (V15, CNA) are having a hard time maintaining our balance. As we continued to walk, this surveyor and V15, CNA had on coats. V15 stated, It was about this cold when I found (R1) (Confirmed on Accu-Weather website, temperature was 23 degrees Fahrenheit, at this time). There was some wind, but no snow. As we continued to walk on the uneven grass next to the steep incline, which was running parallel to the street, the incline gradually level out with the street eight inch curb. We walked past both the North and South facility buildings. We walked across one parking lot entrance road to the facility. The parking lot entrance to the North building junction with the street was crowded with a steady flow of vehicles. The speed limit posted was 35 miles per hour. V15 stated this steady flow of traffic is the normal for rush hour traffic on the and is about the same time R1 would have been out walking in the traffic. After crossing the parking lot entrance, there was a grassy area approximately 200 feet, next to an apartment complex. Before reaching the apartment parking lot entrance road off the street, there was an approximately 15 feet by 20 feet concrete slab in the grassy area. There was an electrical site warning sign. There were four steel electrical utility transformer boxes on the concrete slab. One of the electrical utility transformer boxes was four foot wide by approximately eight foot long and eight-foot tall. The other three steel electrical utility transformer boxes were approximately three foot tall, by three foot wide and two foot long. The electrical boxes had multiple access doors with pad lock. At the opposite end of the same 200-foot grassy area there was a gas line warning sign. The gas line warning sign was outside of four concrete, two and a half feet tall pillars. The four pillars sat in a square pattern approximately eight feet apart. Inside the four concrete pillars there were multiple metal gas pipes. The gas pipes varied in sizes of approximately two- and three-inch diameters. The metal pipes looked like a play structure for children. The metal gas pipes crossed each other in jungle gym fashion at different</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145753	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER LA Bella of Danville		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>This surveyor measured the mileage by car. R1 traveled on foot on 1/1/25. The distance one way by car, from the facility to where R1 was found, measured four tenths of a mile. This does not include the facility sidewalk distances from the back of the south building to the front of the south building, where R1 had left his wheelchair.</p> <p>The National Oceanic and Atmospheric Administration ((NAME)) website documents on 01/01/25 at 4:35 pm, in this city it was 30 degrees Fahrenheit with 10 mile per hour winds, equal to real feel temperature on the skin of 21 degrees Fahrenheit.</p> <p>On 1/15/25 at 7:20 am V7, Medical Director stated he was informed of several of R1's elopements. None of R1's elopements or attempts reported to V7 by the facility included (R1) that exited the building and was walking down street unassisted. V7 stated V7 did not know R1 was off the facility grounds. V7, stated R1 has Dementia, has been sent to the emergency room post-falls because he is on a blood thinner and had hit his head. V7 stated is his standard protocol to have a resident on blood thinners evaluated at the hospital post unwitnessed falls and witnessed to have hit their head during a fall. V7 stated, I had not heard a door alarm malfunctioned either. Alarms in the ER (emergency room) go off all the time. I even had a patient go hypoxic. No one initially responded to the alarm. It is the same in nursing homes. I think the staff are immune to the sounds of the alarms. They hear them often. (R1) should have been closely supervised to prevent this from happening. His (R1's) Dementia alone put him at risk of elopement. Having had falls, the short time he was in the facility, also put him at risk serious of injury. To hear he was out walking in the street, in cold temperatures, adds to the potential for serious harm. Knowing he had not been assessed by the nurse when he returned to the facility, is even more concerning. A full assessment should have been completed immediately, to have gotten a full picture of any harm after the incident. Adequate supervision may have changed all. Yes, he was at great risk of serious injury.</p> <p>On 1/22/25 at 1:30 pm V38, CNA stated no one had seen (R1) for about an hour. V38 stated V8, Registered Nurse asked everyone night after the facility got a call that R1 was outside the facility.</p> <p>R1's Care Plan dated 12/31/24 does not document an elopement care area until 01/01/25. R1's care Plan documents the following: (R1) is an elopement risk/wanderer related to restlessness and agitation. (R1) cut off his (departure alert) bracelet. Date Initiated: 01/01/2025.</p> <p>He will not leave facility unattended through the review date. Date Initiated: 01/01/2025.</p> <p>His safety will be maintained through the review date. Date Initiated: 01/01/2025.</p> <p>Assess for fall risk Date Initiated: 01/01/2025, Enhanced supervision: 1:1 (one on one) within line of sight. Date Initiated: 01/01/2025 (Departure Alert Device) in place on left ankle. Monitor device is functioning properly, daily.</p> <p>The facility presented an abatement plan to remove the immediacy on 1/16/25. The survey team reviewed the abatement plan and accepted the abatement plan on 1/21/25.</p> <p>The Immediate Jeopardy began on 1/01/25 was removed on 1/23/24 when the facility took the following actions to remove the immediacy:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER LA Bella of Danville		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> 1. Confirmed the facility identified residents affected or likely to be affected by completing resident elopement assessments and reassessments and updating care plans. Completed by V1, Administrator V2, DON, V6, ADON/ QA Nurse, V10 Social Service Director (SSD) South, V11, SSD North, V28, ADON Evening shift on 1/2/2025. 2. Confirmed elopement binder was updated and at the nurses' stations, and the reception desk. Completed by V10 on 1/2/25. 3. Confirmed Accidents and Incidents- Investigating and Reporting Policies including documentation of the condition of the affected person, including vital signs was revised and updated. Completed by V9, [NAME] president of Clinical Services on 1/2/25. 4. Staff training was initiated and is ongoing as of 1/23/25. In-service training on elopement protocol and retention quiz were not provide prior to start of shift for several staff. The surveyor confirmed a sample of staff not in-serviced, which included: V36, Housekeeper, V40 Housekeeper, V41, CNA, V43, LPN, V45 CNA, and V50 Laundry, and Agency staff included: V34, CNA, V44, LPN, V47 LPN, V48, LPN, and V49, CNA. All staff identified stated they have been working in the facility throughout the month of January. V1, Administrator acknowledged all staff have not been educated as planned, as of this exit date 1/23/25. 5. Confirmed V1, V2 and V28 Assistant Director of Nurses initiated education relating to immediate head to toe assessments following unusual occurrences. Completed on 1/2/2025. 6. Confirmed V12, Maintenance Director assessed all doors, exit alarms, and the departure alert system to ensure proper working order and observed during survey. Ad-Hoc QAPI (Quality Assurance Performance Improvement) meeting was completed on 1/2/2025 discussing event and evaluating the current elopement program including conducting daily assessments of exits, and routinely scheduled elopement drills to be ongoing. One mock drill was completed during survey. Completed 1/2/25 and ongoing. 7. Confirmed V1, provided training to the IDT (Interdisciplinary team) regarding development of care plans to address residents who are newly identified with exit-seeking /wandering behaviors and elopement risk. Completed 1/2/25 and is ongoing. 8. Confirmed Ad-Hoc QAPI meeting, including the Medical Director by phone, to discuss the incident and the corrective actions to prevent similar events. Completed 1/2/25 and ongoing. 9. Confirmed in interviews, Daily IDT meetings were conducted to discuss new or worsening wandering/exit-seeking behaviors. Any new and/or worsening behaviors will be addressed by ensuring appropriate clinical interventions are implemented to prevent an incident of elopement. 1/2/25 and ongoing. 10. Confirmed QAPI team will review results of the audits, posttests, door and window checks. The QAPI team will determine if additional monitoring or corrective actions are necessary based on the review of monitoring activities. Completed 1/2/25 and ongoing. 		