

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 05/13/2025
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172</p> <p>Based on interview and record review the facility failed to protect resident's rights to be free from verbal and physical abuse from another resident. This failure affected three of five residents (R4, R5, R8) reviewed for abuse in the sample of eight.</p> <p>Findings Include:</p> <p>The facility's Abuse Prevention and Reporting- Illinois policy dated August 2023 documents the facility affirms the right of its residents to be free from abuse. The policy defines Abuse as the willful infliction of injury. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse as the infliction of injury on a resident. Physical abuse includes hitting, slapping, and other similar behaviors. The policy defines Mental Abuse as the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. Verbal Abuse is defined as the use of oral, written, or gestured communication to residents within hearing distance regardless of age, ability to comprehend, or disability. Verbal abuse can include harassing, mocking, insulting, or ridiculing a resident. Resident-to-resident altercations that include any willful action that results in physical injury, mental anguish or pain must be reported in accordance with regulations.</p> <p>1. The Serious Injury and Communicable Disease Report dated 4/22/25 documents R4 and R5 were involved in an altercation. At approximately 7:45 PM on 4/22/25, R4 attempted to touch the watch on R5's arm. R5 responded by grabbing R4's wrist which created a skin tear to R4's right wrist.</p> <p>R4's Medical Diagnoses List dated May 2025 documents R4 is diagnosed with Dementia with Psychotic Features, Mental Disorder, Anxiety, Bipolar Disease, Psychotic Disorder with Delusions, Violent Behavior, and Altered Mental Status.</p> <p>R4's Minimum Data Set, dated dated dated [DATE] documents R4 is severely cognitively impaired.</p> <p>R4's Care Plan dated 2/12/25 documents R4 wanders and is at moderate risk for abuse.</p> <p>R5's Medical Diagnoses List dated May 2025 documents R5 is diagnosed with Dementia with Agitation, Generalized Anxiety Disorder, and Insomnia.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R5's Minimum Data Set, dated dated dated [DATE] documents R5 is severely cognitively impaired.</p> <p>R5's Care Plan dated 3/2/25 documents R5 had a behavior problem of cursing and hitting staff and has mood swings. R5 is also physically aggressive and strikes out and scratches. R5 is also a moderate risk for abuse.</p> <p>R5's Abuse Neglect Screening dated 3/2/25 documents R5 has behaviors that may provoke a reaction by residents or others which include but are not limited to: verbal aggression, insults to race or ethnicity, physical aggression, inappropriate touching or grabbing, and wandering.</p> <p>On 5/13/25 at 11:46 AM V18 Licensed Practical Nurse (LPN) stated on 4/22/25, he witnessed R4 reach for and grab R5's wristwatch. V18 stated R5 does not like to be touched or grabbed like that. V18 confirmed R5 quickly grabbed R4's arm in retaliation and made a skin tear. R4 yelled out.</p> <p>2. The Serious Injury and Communicable Disease Report dated 5/5/25 documents on 5/5/25 at approximately 1:00 PM R5 and R8 were involved in an altercation.</p> <p>R8's Medical Diagnoses List dated May 2025 documents R8 is diagnosed with Dementia, Alzheimer's Disease, and Mild Cognitive Impairment.</p> <p>R8's Minimum Data Set, dated dated dated [DATE] documents R8 is severely cognitively impaired.</p> <p>R8's Care Plan dated 8/21/23 documents R8 has the potential for aggressive behaviors and is at high risk for abuse.</p> <p>R8's Abuse Neglect Screening dated 2/25/25 documents R8 has a history of mistreating others with verbal/physical/sexual abuse.</p> <p>On 5/8/25 at 4:15 PM V9 Certified Nurse Assistant (CNA) stated she was at the nurses' station and witnessed R5 sitting in her wheelchair in the middle of the hallway. R8 was attempting to push R5's wheelchair out of the way. R5 got upset and started swinging her arms in R8's direction. V9 is unsure if R5 was able to hit and make contact with R8, however R8 became upset and hit R5 across her face right beside her cheek and eye area. V9 stated R8 hit R5 hard and R5 was holding her face and then preceded to call R8 a N***** (racial slur).</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</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>35347</p> <p>Based on interview and record review, the facility failed to effectively supervise R3 to prevent falls. This failure resulted in R3 falling from R3's wheelchair to the floor in R3's room. This failure affects one resident (R3) of three reviewed for accidents in the sample of eight.</p> <p>Findings Include:</p> <p>R3's diagnosis list (printed 5/7/2025) documents R3's diagnoses include: Cerebral Infarction (stroke), Personal History of Transient Ischemic Attack (temporary disruption of blood flow to the brain causing stroke-like symptoms), and Alzheimer's Disease.</p> <p>R3's Admission Assessment (3/13/2025) documents R3 has severe cognitive impairment, uses a wheelchair, and is dependent on staff for mobility and transfers from the wheelchair to other surfaces.</p> <p>The facility fall log (April, 2025) documents R3 experienced falls in the facility on 4/1/2025, 4/12/2025, and 4/13/2025.</p> <p>R3's Care Plan (printed 5/7/2025) documents R3 is at risk for falls and a new intervention starting on 4/1/2025 for staff to place R3 in bed after meals.</p> <p>The facility Post Fall Huddle (4/1/2025) documents R3 experienced an unwitnessed fall in R3's room on 4/1/2025 when R3 attempted to get up from R3's wheelchair to walk. The same record documents interventions to prevent further reoccurrence/falls including frequent checks and education for staff to keep R3 in a common area or monitored when in R3 is in R3's wheelchair.</p> <p>R3's medical progress notes (4/2/2025) document R3 experienced a fall on 4/1/2025, is at high risk for falls, and staff should place R3 in bed after all meals.</p> <p>R3's Progress Notes (4/12/2025) document R3 experienced a subsequent fall in R3's room on 4/12/2025 at 3:05PM. The same report alleges R3 was transferred by two staff members from the floor to the bed after the fall and documents, educate staff to lay (R3) down after all meals.</p> <p>On 5/7/2025 at 12:32PM, V2 (Director of Nursing) reported R3's 4/12/2025 fall was witnessed by V6 (Certified Nurse Aide).</p> <p>On 5/8/2025 at 2:37PM, V6 denied being present in the facility on 4/12/2025 when R3 experienced a fall from the wheelchair to the floor. V6 reported being away from the facility on scheduled vacation on 4/12/2025.</p> <p>On 5/8/2025 at 2:50PM, V2 (Director of Nursing) then reported V6 was not the facility staff member who witnessed R3's fall on 4/12/25 but the staff member was V10 (Certified Nurse Aide).</p> <p>On 5/8/2025 at 3:03PM, V10 denied ever witnessing any of R3's falls and denied witnessing R3's fall occurring on 4/12/2025.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/9/2025 at 10:48AM, V2 (Director of Nursing) then alleged the facility staff member taking care of R3 on 4/12/2025 who observed R3 fall from the wheelchair was V11 (Minimum Data Set Coordinator).</p> <p>On 5/9/2025 at 2:17PM, V11 reported allegedly being present when R3 fell to the ground on 4/12/2025 from R3's wheelchair and reported V12 (Certified Nurse Aide) was the staff member who helped V11 move R3 off the floor after the fall. V11 denied knowing if staff had placed R3 into bed following lunch on 4/12/2025 prior to the fall occurring at 3:05PM.</p> <p>On 5/9/2025 at 2:32PM, V12 (Certified Nurse Aide) denied ever witnessing any of R3's falls and denied helping V11 move R3 off the floor after R3's fall on 4/12/2025.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>35347</p> <p>Based on interview and record review, the facility failed to administer five consecutive doses of ordered intravenous antibiotic medication. This failure affects one resident (R3) of one reviewed for medication administration in the sample of eight.</p> <p>Findings Include:</p> <p>R3's diagnosis list (printed 5/7/2025) documents diagnoses including: Cutaneous Abscess of Buttock and Encounter for Change or Removal of Non-surgical Wound Dressing.</p> <p>R3's Care Plan (printed 5/7/2025) documents R3 has a history of wound infection requiring antibiotic treatment.</p> <p>R3's wound treatment timeline (undated) documents R3 was to start antibiotic treatment for a wound infection on the morning of 4/19/2025.</p> <p>R3's Order Entry (4/18/2025 at 6:44PM) documents a medical order for R3 to begin antibiotic treatment with Unasyn, 1.5 grams, intravenously every eight hours.</p> <p>R3's medication administration record (April, 2025) documents R3 did not receive the first dose of the above ordered antibiotic until 4:00PM on 4/20/2025.</p> <p>V13's handwritten note (5/7/2025) documents facility staff did not notify V5 (R3's wound care medical provider) of the above missed antibiotic doses.</p> <p>On 5/9/2025 at 2:50PM, V3 (Assistant Administrator) reported an expectation for facility staff to reach out to a prescribing medical provider within a day's time if they are unable to provide a medication ordered for a resident.</p>