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	06/12/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect a resident's right (R2) to be free from physical abuse by another resident (R1). This failure affects two (R1, R2) of four residents reviewed for abuse in the sample list of four residents. Findings include: On 6/11/25 at 1:02 PM R2 was in her room. R2 was asked if anyone had hurt her recently. R2 stated yes, and pointed to the top of her left hand which had a scab and faded bruising. R2 stated, He (R1) started punching me (R2) while making a fist motion with both hands. R2 was unable to provide any additional information regarding this incident. R2's Brief Interview for Mental Status dated 3/24/25 documents R2 has severe cognitive impairment. The Long-Term Care Facility & IID - Serious Injury Incident Report dated 6/9/25 documents the following: On 6/2/25 at 3:45 PM V8 Certified Nursing Assistant (CNA) was sitting at the nurses' station. R1 was sitting in his wheelchair in front of the nurses' station facing the dining room. V8 witnessed R2 walk past R1, R2 was out of R1's line of sight and patted R1 on the head. V8 witnessed R1 then quickly hit R2 in the abdomen and left hand with R1's closed fist. R2 sustained a 0.5 centimeter (cm) by 0.75 cm by 0.1 cm skin tear to the left hand. R1's Minimum Data Set, dated [DATE] documents R1 has severe cognitive impairment. R1's active Care Plan documents R1 has delusions, strikes out, can be physically aggressive towards others, and curses; and R1 receives psychiatric services. R1's April 2025 Medication Administration Record (MAR) documents R1 received Olanzapine (antipsychotic) 15 milligrams by mouth daily for Dementia with behavioral disturbances. This medication was reduced to 12. 5 milligrams daily on 4/3/25. R1's May 2025 MAR documents R1 had physical behaviors noted on 5/11/25, recorded by V13 Licensed Practical Nurse (LPN). R1's Nursing Note dated 5/4/25 at 8:11 PM documents R1 was yelling and swinging at unidentified residents. R1's Nursing Note dated 6/1/25 at 3:38 PM staff were assisted R1 with incontinence care. R1 grabbed his soiled undergarment and pants and R1 punched the nursing staff in the chest and head. R1 grabbed staff's hand and began to bend her fingers backwards. R1 was verbally aggressive and using profanity towards the nursing staff. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Psychiatry Note dated 5/15/25 documents R1 appears to have been tolerating the Olanzapine gradual dose reduction and R1 hasn't had any behaviors. There is no documentation R1's physical behaviors noted on 5/4/25, 5/11/25, and 6/1/25 were reported to a physician/provider prior to the altercation with R2 on 6/2/25. On 6/11/25 at 1:42 PM in reference to R1's/R2's incident on 6/2/25, V8 CNA stated V8 was sitting at the desk area and R1 was drowsy and leaning forward in his chair. V8 stated R2 walked up behind R1, R2 patted R1 lightly on the head and R1 went [NAME], [NAME], [NAME] with his (R1's) fists on her (R2's) hand and leg which caused a skin tear on R2's hand. V8 made a punching motion with V8's hands. V8 stated it happened so fast before V8 could separate R1 and R2. V8 stated it was out of the ordinary for R1 to do that. V8 stated R1 was just startled by R2. On 6/11/25 at 3:12 PM, in reference to R1's 5/4/25 nursing note, V15 Registered Nurse stated R1 is sometimes aggressive and will get angry for no reason. V15 stated that day activity staff reported R1 was swinging at unidentified residents, no contact was made, and residents were separated. V15 stated the facility has psychiatric providers that round weekly at the facility and behaviors are reported to the providers. V15 stated V15 was unsure if V15 had reported R1's behaviors on 5/4/25 and this wouldn't be documented anywhere. On 6/11/25 at 3:34 PM V5 Dementia Unit Director confirmed after R1's medication reduction on 4/3/25. R1 was only seen by a psychiatry provider on 5/15/25. V5 stated V18 Nurse Practitioner evaluated R1 after the incident with R2, and increased R1's Olanzapine. On 6/12/25 at 10:19 AM in reference to R1's 5/11/25 MAR entry, V13 LPN stated R1 was being aggressive with the CNAs, cussing and hitting them. V13 stated V13 is employed through an agency and facility staff told V13 that's how R1 acts. V13 stated R1 can get aggressive with other residents, so we try to de-escalate those situations. On 6/12/25 at 10:34 AM in reference to R1's 6/1/25 nursing note, V14 LPN stated that was a behavior R1 hadn't done in a long time. V14 stated R1 was incontinent and was agitated with staff, so we left him for a little bit to calm down. V14 stated R1 wasn't fully dressed so an unidentified CNA went back into R1's room to try to change R1. R1 grabbed the CNAs hand and bent her fingers backwards when the CNA attempted to wipe R1. V14 stated both of the CNAs were agency staff. V14 stated V14 has never known R1 to be physical, but R1 is verbally aggressive. V14 stated R1 calmed down some but didn't return to his baseline that shift. V14 stated R1 is the type that you have to aggravate him to get him going. V14 stated V14 would not have been surprised if R1 had a Urinary Tract Infection, because R1's behavior that day was not his norm. V14 stated V14 called V17's (R1's Physician) office that day and left a message regarding R1's behavior, but V14 did not speak with anyone or receive a call back. The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated April 2021 documents residents have the right to be free from abuse. This policy includes the objective to protect residents from abuse, including abuse from other residents.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement person centered activities and interventions for dementia care for one (R1) of four residents reviewed for abuse in the sample list of four. Findings include: The facility's Dementia Clinical Protocol dated November 2018 documents, For the individual with confirmed dementia, the IDT will identify a resident-centered care plan to maximize remaining function and quality of life. Direct care staff will support the resident in initiating and completing activities and tasks of daily living. Bathing dressing, mealtimes, and therapeutic and recreational activities will be supervised and supported throughout the day as needed. The IDT (Interdisciplinary Team) will adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, and other relevant factors. On 6/11/25 at 1:02 PM R2 was in her room. R2 was asked if anyone had hurt her recently. R2 stated, yes, and pointed to the top of her left hand which had a scab and faded bruising. R2 stated he (R1) started punching me (R2) while making a fist motion with both hands. R2 was unable to provide any additional information regarding this incident. R2's Brief Interview for Mental Status dated 3/24/25 documents R2 has severe cognitive impairment. The Long-Term Care Facility & IID - Serious Injury Incident Report dated 6/9/25 documents the following: On 6/2/25 at 3:45 PM V8 Certified Nursing Assistant (CNA) was sitting at the nurses' station. R1 was sitting in his wheelchair in front of the nurses' station facing the dining room. V8 witnessed R2 walk past R1, R2 was out of R1's line of sight and patted R1 on the head. V8 witnessed R1 then quickly hit R2 in the abdomen and left hand with R1's closed fist. R2 sustained a 0.5 centimeter (cm) by 0.75 cm by 0.1 cm skin tear to the left hand. R2's active care plan documents R2 has a diagnosis of Dementia. This care plan was updated on 6/2/25 to include R2's risk for abuse and demonstrates touching other residents on the head, which has the potential to disturb others. Interventions include address R2's concerns, encourage participation in activities, overs for changes in routine, and staff observe during dining rounds and care. R2's care plan does not identify R2's specific person centered activities of interest or that R2 worked as a CNA. This care plan did not include R2's friendly personality and history of getting in other resident's personal space or trying to help others, prior to 6/2/25. On 6/11/25 at 1:18 PM V5 Dementia Unit Director stated R2 likes to rub others' shoulders or pat them, but not in an aggressive nature. V5 stated R2 used to be a CNA and tries to help others. At 3:34 PM V5 reviewed R2's care plan and confirmed there are no person centered specific activities of interest. V5 confirmed R2's care plan did not include R2's history of being in others' personal space prior to 6/2/25. On 6/11/25 at 1:20 PM V3 CNA stated R2 participates in activities and likes to do crafts and go outside. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 1:31 PM V6 Activity Aide stated R2 used to be a CNA and likes to help and do things. V6 stated R2's activities are getting manicures, music, and going outside. On 6/12/25 at 9:10 AM V6 stated R2 is friendly and tries to help other residents. V6 stated R2 gets in other resident's personal space, but not in a negative way; and R2 has been that way since R2 admitted to the facility. V6 stated activity interests should be care planned and participation is documented on the activity participation logs. V6 stated V6 works Monday-Friday providing activities on the dementia unit where R2 resides. On 6/11/25 at 1:42 PM in reference to R1's/R2's incident on 6/2/25, V8 CNA stated V8 was sitting at the desk area and R1 was drowsy and leaning forward in his chair. V8 stated R2 walked up behind R1. R2 patted R1 lightly on the head and R1 went [NAME], [NAME], [NAME] with his (R1's) fists on her (R2's) hand and leg which caused a skin tear on R2's hand. V8 made a punching motion with V8's hands. V8 stated R1 was just startled by R2 and R2 had patted other residents several times prior to that incident. V8 stated not everyone likes to be touched and you must approach R1 from the front, so you don't startle R1.