

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 11/20/2025
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)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to identify, report and investigate a fall; and failed to implement post fall interventions for one of three residents (R5) reviewed for injuries/accidents in the sample list of 15. Findings include: R5's Minimum Data Set, dated [DATE] documents R5 has severe cognitive impairment, is always incontinent of bowel and bladder, requires substantial/maximal staff assistance with bed mobility and transfers, and dependence on staff for toileting hygiene. R5's Quarterly Assessments form dated 7/14/25 documents R5 has an unsteady gait, is confused, and is at high risk for falls. R5's active Care Plan documents a problem dated 9/24/25: R5 likes to sit on the floor. This care plan documents a problem, dated 9/14/24, is at high risk for falls related to history of falls and weakness, and interventions include room change to North building for increased observation/monitoring, attempt to anticipate needs, check/change offer frequent toileting, call light in reach, encourage call light use, and call don't fall sign in room. R5's Nursing Note dated 9/5/2025 at 6:28 PM documents nurse (V32 Registered Nurse (RN)) found R5 sitting on his bottom in his room next to his chair with his knees to his chest and scratching at the baseboard of the wall. R5 was asked if R5 fell and R5 responded, No I (R5) am trying to clean the wall. R5 was assessed for injuries with no injuries noted. R5 agreed to get back into his wheelchair and was taken to activities. V2 Director of Nursing (DON) was notified that R5 placed himself on the floor. The facility's undated fall log with date range August 2025 - November 2025 does not document R5 fell on 9/5/25. There is no documentation that R5 found on the floor on 9/5/25 was reported to R5's family or physician, or that the facility investigated and developed new interventions. R5's Nursing Note dated 10/5/25 at 7:46 AM documents at approximately 5:00 AM an unidentified Certified Nursing Assistant (CNA) heard a sound from R5's room and found R5 on the floor mat next to R5's bed. It appeared that R5 had slid down from the bed. R5 was assessed and alert, denied hitting his head. Approximately 30 minutes later R5 had a new large hematoma (swelling/bruising) and skin tear on his right forearm. Due to R5 being on aspirin R5 was sent to the hospital for evaluation. R5's 10/5/25 fall investigation file, provided by V2 DON on 11/19/25 at 1:35 PM V2 DON, did not include documentation that staff were interviewed to determine when R5 was last observed and toileted prior to his fall. R5's Care Plan Summary Note dated 10/6/25 at 12:40 PM documents the interdisciplinary team reviewed R5's 10/5/25 fall and determined the root cause as attempting to self-transfer to get up for the day. The post fall intervention was for R5 to be added to the early morning get up list. On 11/19/25 at 12:31 PM R5 was lying in bed with head of bed elevated, R5's call light was on top of his night stand which was behind R5 and out of his reach. R5 stated he had slid out of his wheelchair while sitting on a pillow and recently fell out of his wheelchair and bumped his arm. There was golf ball sized hematoma to R5's right inner forearm, near elbow. R5 was unable to give any additional details regarding his falls. R5 stated R5 uses his call light. R5 was asked where his call light was. R5 searched his bed and railing and could not find his call light. There was no signage in R5's room reminding R5 to use his call light. On 11/19/25 at 12:37 PM V32 RN stated R5 tries to self-transfer and R5's fall interventions include fall mat, frequent toileting and keeping R5 busy with activities. V32 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 145753	Facility ID: 145753 If continuation sheet Page 1 of 2

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated most of R5's falls have happened when R5 was trying to fix something and R5 has behaviors of putting himself on the floor. V32 stated the care plan documents resident fall interventions. V32 stated R5 does use his call light, and it should be within reach. V32 entered R5's room and removed R5's call light from his dresser and applied it to R5's bed rail. V32 stated R5 has not gotten out of bed yet today and his call light should be clipped to his bed or attached to the bedrail. At 2:34 PM V32 stated if R5 is found on the floor but not witnessed by staff to intentionally place himself on the floor, then it is considered a fall. V32 was asked about R5's 9/5/25 Nursing Note. V32 stated since R5 was found sitting on the fall mat, V32 did not consider it to be a fall and therefor did not notify R5's family or physician. V32 confirmed staff did not witness R5 place himself on the floor mat. On 11/19/25 at 12:59 PM V28 CNA stated R5 has confusion and attempts to self-transfer more so out of the wheelchair than his bed, and R5 requires limited assist of one staff person for transfers. R5 does use his call light and does not have a sign to remind R5 to call don't fall. V28 entered R5's room and confirmed there were no signs posted to remind R5 to use his call light. V28 stated V28 would look at the care plan/Kardex to determine fall interventions. On 11/20/25 at 9:00 AM V34 Licensed Practical Nurse stated R5 had an unwitnessed fall during the early morning on 10/5/25. V34 stated an unidentified CNA heard a noise and found R5 sitting on the floor mat next to his bed. V34 stated R5 was confused and could not say why R5 was trying to get up. V34 stated V34 last saw R5 in bed shortly before the fall occurred but was unsure the time that R5 was last toileted. V34 said, About 30 minutes later we noted swelling to (R5's) arm, notified the physician and sent (R5) to the hospital for x-rays. On 11/9/25 at 3:09 PM V2 DON stated V2 was unsure which CNA found R5 on the floor on 10/5/25. V2 stated when R5 resided in the South building, R5 wouldn't wait for staff assistance to get changed or toileted, and V2 had to assist R5 at times. V2 confirmed all R5's 10/5/25 fall investigation documentation was provided. V2 stated he interviews staff for unwitnessed falls to see when residents were last checked on and toileted prior to the fall but does not always have documentation of this. V2 confirmed this information was not documented for R5's 10/5/25 fall. V2 stated if we know a resident has a behavior of putting themselves on the floor but we don't see it happen, then it should be considered a fall. V2 confirmed falls should be reported to the physician and family. V2 stated neurological checks should be done for unwitnessed falls. On 11/20/25 at 10:30 AM V2 stated V2 spoke with staff regarding R5 being found on the floor on 9/5/25 and reviewed the nursing note. V2 stated R5 was found on the mat with his knees up and R5 denied that he had fallen. V2 stated R5 told staff he was cleaning the baseboard and R5 is care planned for putting himself on the floor. V2 stated this was not considered to be a fall. V2 confirmed R5 was not witnessed putting himself on the floor, this was not investigated, and no new interventions were developed. V1 Administrator confirmed it could not definitively be determined that R5 did not truly fall since this was not witnessed. V3 Assistant DON stated R5's confusion waxes and wanes, with some days being better than others. The facility's Managing Falls and Fall Risk policy, dated March 2018, documents unless there is evidence otherwise, when a resident is found on the floor it should be considered a fall. This policy documents staff and the physician will give input to develop and implement a resident centered fall prevention plan and implement additional interventions if falling recurs. This policy documents staff will re-evaluate the situation and whether to continue or change interventions.		