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 02/20/2026
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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 residents' right to be free from sexual abuse and assault perpetrated by another resident (R5) with known sexual behaviors. This failure affects two residents (R4 and R6) on the sample list of fourteen. This failure resulted in immediate jeopardy. The immediate jeopardy began on 2/2/26 at approximately 10:30 am when R5 made sexual contact with R4 and R6. V1, Facility Administrator, was notified of the immediate jeopardy on 2/13/26 at 11:15 am. The surveyor confirmed by interview and record review, the Immediate Jeopardy was removed on 2/16/26, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include:R4's Census Detail and Medical Diagnoses List, both dated 2/10/26, document R4 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease, transient ischemic attacks (mini strokes), altered mental status, muscle weakness, difficulty walking, and need for assistance with personal care.On 2/6/26 at 10:33 AM, R4 was seated in a wheelchair in the hallway next to the nurses' station. R4 could not formulate a response relevant to questions being asked. R4 continuously pointed her right index finger in different directions and spoke in a mumbling manner, occasionally uttering sensible words about brother or cooking.R4's Care Plan dated 1/9/26 documents R4 is at risk of abuse. A prior Care Plan dated 4/3/24 documented R4 was at low risk of abuse and was revised on 5/8/25 to reflect R4 was the alleged victim of abuse from another resident on 5/7/25.The facility's Serious Injury Initial Report dated 5/7/25 documents an allegation R5 had touched the breasts of R4.The facility's Center for Medicare and Medicaid Services Form 2567 (Statement of Deficiencies) and associated Resident Numerical Reference dated 4/17/24 document a cited incident involving R5 (then R205) as the perpetrator of sexual abuse toward R4 (then R206), in which R5 touched R4's breasts.R6's Census Detail and Medical Diagnoses List, both dated 2/10/26, document R6 was admitted to the facility on [DATE] with diagnoses including dementia, depression, pseudobulbar affect, reduced mobility, anxiety, lack of coordination, and bipolar disorder. The same list documents an additional diagnosis of confirmed adult sexual abuse dated 2/4/26.On 2/6/26 at 10:55 AM, R6 was seated in a wheelchair in her room. R6 made no verbal responses to questions and only produced intermittent humming noises. R6 wheeled herself through her room, into the hallway, and back into her room without any apparent direction or intended destination.R6's Care Plan dated 2/5/26 documents R6 experienced sexual assault by another resident, placing her at risk for emotional distress, physical harm, and a compromised sense of safety. A prior Care Plan dated 6/2/25 documents R6 is at risk of abuse.R5's Census Detail and Medical Diagnoses List, both dated 2/10/26, document R5 was originally admitted to the facility on [DATE] with diagnoses including cerebral infarction, anxiety, mood disorder, high-risk heterosexual behavior (7/30/24), schizoaffective disorder bipolar type, and moderate vascular dementia with agitation.R5's Care Plan initiated 1/6/25 documents R5 wanders aimlessly throughout the facility. The (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

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 02/20/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	same Care Plan documents R5 inappropriately touches other residents and staff and makes inappropriate comments. A Care Plan dated 1/6/25 further documents R5 is an identified offender with a criminal history including domestic battery (2003), battery and resisting a peace officer (1986), contempt of court (1983), and thefts and burglaries (1983, 1995, and 2006).On 2/6/26 at 10:24 AM, V11 (Housekeeper) stated on 2/2/26 she noticed two wheelchairs in R6's room. Knowing R6 resided alone, she entered to determine why there was a second wheelchair present. V11 stated R6 was lying on the bed and R5 had his hand in R6's diaper area. V11 clarified R6 was not wearing her diaper. V11 reported she informed Certified Nursing Assistant V13 and Nurse V12 about what she saw.On 2/6/26 at 10:40 AM, R5 was seated in a wheelchair in the main dining room engaged in an occupational therapy activity. R5 had a small quart-sized bucket of clothespins colored green, red, blue, and yellow, along with a stack of colored and numbered cards. R5 drew a card from the deck (observed as a green 6), selected and counted six green clothespins, and clipped them to the card-three with his right hand and three with his left. He received no instructions while performing the activity. A stack of completed cards was in front of him, with a yellow number one card on top holding one yellow clothespin.During the observation, R5 stated he did not have any girlfriends at the facility because every time he picked one, she would pick another man. R5 stated there were a few women he would like to talk to, but they did not want to talk to him. R5 stated he had touched one woman down below, then clarified on her pu*s (vagina) and stated it occurred in her room. R5 added he thought the woman wanted him to touch her but couldn't prove it.On 2/6/26 at 1:10 PM, V12 (Licensed Practical Nurse) stated she had been the nurse on duty on 2/2/26 when V11 reported seeing R5 touching R6 in her diaper area. V12 stated she responded to R6's room to remove R5 and observed R6's bed sheet pulled to the side, R6's incontinent undergarment unfastened, and R5's finger inside R6's vagina.On 2/6/26 at 1:50 PM, V3 (Assistant Director of Nursing) confirmed the incident involving R5 touching R6 occurred on 2/2/26. V3 stated R6 went to the emergency room for evaluation on 2/3/26 because initial reports indicated R5 had been touching R6 in her diaper and thigh area, which was why the Nurse Practitioner (V9) initially conducted only a brief visual examination. V3 further stated after administrative investigation began, witnessing staff reported actual vaginal touching and penetration had occurred.On 2/6/26 at 3:22 PM, V13 (Certified Nursing Assistant) stated she had received V11's report about R5 touching R6 in her diaper area. V13 stated she had provided care for R6 approximately 15-20 minutes prior and R6 was in bed with her undergarment fastened and covered with a sheet at time. When V13 arrived after the report, R6's sheet was pulled aside, her undergarment was unfastened exposing her genital area, and R6 was tearful. V13 stated this was the second report she had received about R5 day. She reported a family member (V21) of another resident (R11) informed her R5 had grabbed R4 in her private area in the dining room.On 2/11/26 at 8:55 AM, V21 (family member of R11) stated she witnessed R5 poking his finger into the private area of R4. V21 stated she moved R5's wheelchair to prevent further contact and informed Certified Nursing Assistant V13 when she arrived. V21 stated both residents were in wheelchairs, so the action could not have been accidental, and she believed R5's actions were intentional.On 2/11/26 at 3:24 PM, V2 (Director of Nursing) stated neither R4 nor R6 had the cognitive capacity to consent to sexual activity.On 2/11/26 at 4:20 PM, V1 (Administrator) confirmed neither R4 nor R6 had the cognitive capacity to consent.The facility's Investigative Report (partially completed) dated 2/3/26 documents an initial interview with V12 conducted by V1 and V2, during which V12 reported receiving V11's report R5 had his hand in R6's diaper area. V1 documented V12 appeared uncomfortable being interviewed by two males and noted V3 would conduct a follow-up interview. During interview, V12 demonstrated what she saw and stated when she entered R6's room, R5 had his finger inside R6's (continued on next page)

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	02/20/2026

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	vagina.R5's Nursing Progress Note dated 2/2/26 documents R5 was evaluated by Nurse Practitioner V9 at 11:18 AM due to sexually inappropriate touching of another resident. A note dated 2/3/26 documents R5 was placed on one-to-one supervision at 11:59 AM.R6's Nursing Progress Note dated 2/2/26 at 11:38 AM documents she was evaluated by Nurse Practitioner V9 after being touched sexually in an inappropriate manner.The facility policy Identifying Types of Abuse dated September 2022 defines sexual abuse as any nonconsensual sexual contact of any kind with a resident, including unwanted touching, especially of the breasts or perineal area, and all types of sexual assault. The facility policy Abuse, Neglect, and Exploitation dated 10/1/25 documents the facility will implement policies to prevent all types of abuse.Surveyor confirmed onsite the facility took the following measures to remove the immediacy on 2/16/26:R5 was placed on one-to-one continuous supervision on 2/3/26 at approximately 9:45 AM.R5 was assessed by an emergency room provider on 2/2/26, Social Services V4 on 2/2/26, and a psychotherapy provider on 2/3/26.R4 received a head-to-toe nursing assessment on 2/3/26 by Registered Nurse V22.R6 received physician notification and medical evaluation on 2/2/26 by Nurse Practitioner V9.R5 received physician notification and medical evaluation on 2/2/26 by Nurse Practitioner V9.R5 received a psychosocial assessment and emotional support on 2/3/26 by Social Services V4.R4 received a psychosocial assessment and emotional support on 2/5/26 by Social Services V4.R6 received a psychosocial assessment and emotional support on 2/5/26 by Social Services V4.Families/responsible parties for R5 and R6 were notified on 2/3/26 by Social Services V4.R4's family/responsible party was notified on 2/5/26 by Social Services V4.Law enforcement and state reporting requirements were completed for R5 and R6 on 2/3/26 by Administrator V1.Law enforcement and state reporting requirements were completed for R4 and R5 on 2/5/26 by Administrator V1.R6 was transferred to the hospital for evaluation and relocated to the south building upon return on 2/4/26.A facility-wide resident assessment for abuse risk was conducted by Social Services V15, Care Plan Coordinator V37, Director of Nursing V2, and Assistant Director of Nursing V3, completed 2/16/26.All-staff in-service training for abuse prevention was conducted on 2/3/26 by Administrator V1, Director of Nursing V2, Assistant Director of Nursing V3, and Social Services V4.The Abuse Prevention Policy was reviewed on 2/5/26 by Administrator V1, Director of Nursing V2, and [NAME] President of Clinical Operations V33 to ensure inclusion of defined staff response steps and immediate Director of Nursing and Administrator notification.

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 02/20/2026
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility staff failed to report an allegation of sexual abuse to the administrator. This failure has the potential to affect one resident (R4) out of six reviewed for sexual abuse on the sample list of fourteen.Findings include: On 2/5/26 at 12:18 PM, V1, Administrator, stated he is the facility's abuse coordinator. V1 stated all the facility staff know he is the abuse coordinator and to report all allegations to him. V1 stated he did not have an active investigation concerning an allegation of sexual abuse involving R5 touching R4. On 2/6/26 at 2:20 PM, V1 stated there had been a prior allegation on 5/7/25 that R5 was touching R4 on the breasts. V1 stated R5 seemed to gravitate towards R4. The facility's Initial Reportable Incident dated 5/7/25 documents an allegation of R5 sexually touching R4 on the breasts, an incident allegedly occurring 2 weeks prior to the reporting. The facility's Center for Medicare and Medicaid Services 2567 (statement of deficiencies) and associated Resident Numerical Reference dated 4/17/24 documents a cited incident involving R5 (then R205) as the perpetrator of sexual abuse towards R4 (then R206), with R5 (R205) touching the breasts of R4 (R206). On 2/6/26 at 3:22 PM, V13, Certified Nursing Assistant, stated on 2/2/26 she received a witness report from V21 (Family member of R11) alleging that R5 had grabbed R4 in her private area in the dining room. On 2/11/26 at 8:55 AM, V21, Family Member of R11, stated on 2/2/26 she had witnessed R5 poking his finger into the private area of R4. V21 stated she had to move R5's wheelchair to prevent further inappropriate contact from R5 towards R4. V21 stated she informed the Certified Nursing Assistant (V13) when V13 arrived in the dining room. V21 stated both R5 and R4 were in wheelchairs so there was no way the action was accidental like one of them slipped or tripped and fell into the other one. V21 stated R5's action was intentional. On 2/17/26 at 9:41 AM, V33, [NAME] President of Clinical Operations, confirmed V1 did not receive any report of R5 sexually touching R4 until (surveyor) reported the allegation on 2/5/26. The facility policy Abuse, Neglect and Exploitation dated 10/1/25 documents the facility will train all new employees and existing staff on the reporting process and procedures which include reporting of all alleged violations to the Administrator immediately but not more than two hours if the allegation involves abuse or bodily harm. The facility's Training Sign-in Sheet dated 8/29/25 for abuse prevention and reporting includes the signature of V13.

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 02/20/2026

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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. Based on interview, and record review, the facility failed to separate a resident (R5) from contact with other residents after an allegation of sexual abuse to prevent further sexual abuse and assault. This failure affects one resident (R6) out of six reviewed for sexual abuse on the sample list of fourteen. This failure resulted in immediate jeopardy. The immediate jeopardy began on 2/2/26 at approximately 10:30 am when R5 was left unsupervised after an allegation of sexual abuse towards R4, and sexually assaulted R6 while unsupervised. V1, Facility Administrator, was notified of the immediate jeopardy on 2/13/26 at 11:15 am.The surveyor confirmed by interview and record review, the Immediate Jeopardy was removed on 2/16/26, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Based on interview, and record review, the facility failed to separate a resident (R5) from contact with other residents after an allegation of sexual abuse to prevent further sexual abuse and assault. This failure affects one resident (R6) out of six reviewed for sexual abuse on the sample list of fourteen. This failure resulted in immediate jeopardy. The immediate jeopardy began on 2/2/26 at approximately 10:30 am when R5 was left unsupervised after an allegation of sexual abuse towards R4, and sexually assaulted R6 while unsupervised. V1, Facility Administrator, was notified of the immediate jeopardy on 2/13/26 at 11:15 am.Findings include:On 2/11/26 at 8:55 AM, V21 (family member of R11) stated she witnessed R5 poking his finger into the private area of R4. V21 stated she had to move R5's wheelchair to prevent further inappropriate contact with R4. She reported informing Certified Nursing Assistant V13 when V13 arrived in the dining room. V21 stated both R5 and R4 were in wheelchairs, so the action could not have been accidental, such as one slipping or falling into the other. V21 stated she believed R5's action was intentional.On 2/6/26 at 3:22 PM, V13 (Certified Nursing Assistant) stated a family member (V21) of another resident (R11) informed her that R5 had grabbed R4 in her private area in the dining room. V13 stated that at the time of the report she had just returned inside after supervising residents who were smoking outside. V13 stated she directed R5 to go down the hall to his room and then went to remove her coat. She stated that while she was hanging up her coat, R5 proceeded down the hall to R6's room, where the second sexual incident occurred. V13 stated when she returned to the dining room after removing her coat, she received a report from V11 (Housekeeper) that R5 was touching R6 in her diaper area. V13 stated that when she arrived at R6's room after V11's report, V12 (Licensed Practical Nurse) was already removing R5 from R6's room. V13 further stated R6's bed sheet was pulled to the side, R6's incontinent undergarment was unfastened exposing her genital area, and R6 was tearful.On 2/6/26 at 10:24 AM, V11 (Housekeeper) stated that on 2/2/26 she observed R6 lying on the bed while R5 was touching R6 in her diaper area. V11 clarified that R6 was not wearing her diaper. V11 stated she reported what she saw to Certified Nursing Assistant V13 and Nurse V12.On 2/6/26 at 1:10 PM, V12 (Licensed Practical Nurse) stated she had been the nurse on duty on 2/2/26 when V11 reported seeing R5 touching R6 in her diaper area. V12 stated she responded to R6's room to remove R5 and observed R6's bed sheet pulled to the side, R6's incontinent undergarment unfastened, and R5's finger inside R6's vagina.The facility policy Abuse, Neglect and Exploitation dated 10/1/25 documents that the facility will implement policies to prevent all types of abuse and will make efforts to ensure residents are protected from psychosocial harm and additional abuse, including room and staffing changes to protect residents from an alleged perpetrator. The policy states staff must respond immediately to protect alleged victims.The facility's staff in-service training for Abuse Prevention and Reporting dated 8/29/25 documents, by signature, that V11, V12, and V13 received abuse prevention training.On 2/11/26 at 4:24 PM, V1 (Administrator) stated he expects staff to take steps to prevent further abuse. V1 stated staff (continued on next page)

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 02/20/2026

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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	should immediately remove the resident from the incident and not call him until the situation is under control. V1 stated it is part of facility policy for staff to remove the perpetrator from the incident. V1 stated he needed to have a conversation with V13 that would include education that removing her coat in that type of situation is not a priority. V1 stated V13 could have taken multiple actions to prevent further abuse but described this as Monday morning quarterbacking, and stated he would discuss what she could do differently in the future, such as moving the perpetrator to the far side of a table and asking other staff to monitor while she reported the incident.Surveyor confirmed onsite that the facility took the following measures to remove the immediacy on 2/16/26:R5 was placed on one-to-one continuous supervision pending full investigation on 2/3/26 at approximately 9:45 AM.R5 was assessed by an emergency room physician on 2/2/26.R5 was assessed by Social Services V4 on 2/3/26.A psychiatric evaluation was requested on 2/3/26 by Assistant Director of Nursing V3 and completed on 2/5/26 by Psychotherapist V49.R6 was assessed for injury, trauma, and psychosocial needs by Registered Nurse V22 and Social Services V4 on 2/3/26.R4 was assessed for injury, trauma, and psychosocial needs by Registered Nurse V22 on 2/3/26 and Social Services V4 on 2/5/26.Families and responsible parties of R5 and R6 were notified on 2/3/26 by Social Services V4.R4's family/responsible party was notified on 2/5/26 by Social Services V4.Law enforcement and required state agencies were notified per mandatory reporting requirements on 2/3/26 and 2/5/26 by Administrator V1.A room change was completed on 2/2/26 to ensure separation of R5 and R6, and R6 was later moved to the south building upon return from emergency room evaluation on 2/4/26.All-staff in-service training for abuse prevention was conducted on 2/3/26 by Administrator V1, Director of Nursing V2, and Assistant Director of Nursing V3.Administrator V1, Director of Nursing V2, and [NAME] President of Clinical Operations V33 reviewed the Abuse Prevention Policy on 2/3/26 to ensure inclusion of a clear step-by-step response protocol following any allegation, mandatory immediate separation of the alleged perpetrator, and immediate notification of the Administrator and Director of Nursing.A facility-wide risk assessment for abuse involving Social Services V15, Care Plan Coordinator V37, Director of Nursing V2, and Assistant Director of Nursing V3 was completed on 2/16/26.