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	04/02/2026

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to have a Registered Nurse (RN) providing services for at least eight consecutive hours a day, seven days a week. This failure has the potential to affect all 146 residents currently residing in the facility.Findings include:The Facility Assessment Tool dated 07/2025 through 04/2026 documents the following: Staffing Plan for licensed nurses: Refer to facility assessment and CMS minimum staffing rule. This same record further documents staffing should include one Registered Nurse (RN) each shift.The Daily Nurse Staffing Sheets dated 2/26/2026 through 3/31/2026 documents no RN coverage for at least 8 consecutive hours a day on 3/1/2026.On 4/1/26 at 11:54am, V27 Regional Nurse Consultant confirmed there was no RN coverage for 8 consecutive hours in the facility on 3/1/2026.The Facility's Midnight Census Report dated 3/20/2026 documents 146 residents reside in the facility.

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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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review the facility failed to accurately transcribe an opioid analgesic medication order and failed to ensure nursing staff questioned and verified a large dose of a high-risk medication (Morphine 500 mg) before administration. This failure resulted in R5 experiencing drowsiness, respiratory depression, and memory loss. R5 was treated with Narcan (opioid antagonist) and later sent to the emergency room. These failures affected one of three residents (R5) reviewed for Pharmaceutical Services on the sample list of ten. The Immediate Jeopardy began on 3/10/26 when R5 was given an overdose of Morphine Sulfate (500 milligrams). V1 Administrator was notified of the Immediate Jeopardy on 3/31/26 at 2:50 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 3/10/26 and the deficient practice corrected on 3/11/26 prior to the start of the survey and was therefore Past Noncompliance. No POC or Revisit will be required. Findings Include: The facility's Medication Administration policy dated 3/10/26 documents medications are administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice. Nurses are to ensure that the six rights of medication administration are followed: right resident, right drug, right dose, right route, right time, and right documentation. Nurses are to review the Medication Administration Record (MAR) to identify the medication to be administered. Nurses are supposed to compare the medication source with the MAR to verify resident name, medication name, form, dose, route, and time, Nurses are to refer to drug reference material if unfamiliar with the medication. All medications are to be signed off when given in the MAR. If the medication is a controlled substance, nurses are to fill out and sign the corresponding narcotic book. The facility's Controlled substance Administration and Accountability policy dated 10/1/25 documents the facility will have safeguards in place to prevent loss, diversion, or accidental exposure. All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided. In all cases the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the Medication Administration Record (MAR), Controlled Drug Record, or other facility specified form. The Controlled Drug Record served the dual purpose of recording both narcotic disposition and patient information. R5's Hospice Orders dated 3/5/26 document an order for Morphine Sulfate (Concentrate) Oral Solution 100 milligrams per 5 milliliters- give 0.25 milliliters by mouth every two hours as needed for moderate pain/air hunger. R5's Physician Order Sheet dated March 2026 documents and order for Morphine Sulfate (Concentrate) Oral Solution 100 milligrams per 5 milliliters- give 30 milliliters by mouth every two hours as needed for moderate pain/air hunger. R5's Medication Administration Record (MAR) dated March 2026, documents on 3/10/26 V9 Registered Nurse (RN) administered approximately 30 milliliters of Morphine Sulfate orally to R5. On 3/25/26 at 2:03 PM V9 Registered Nurse (RN) stated on 3/10/25 at 7:50 AM, she administered approximately 25 milliliters (500 milligrams) of Morphine Sulfate orally to R5 which is 100 times the prescribed dose for R5. V9 stated the order was transcribed incorrectly into R5's Physician Orders and Medication Administration Record. V9 stated she should have verified the order. V9 confirmed she neglected to document the dose she administered on the corresponding narcotic count sheet. V9 stated R5 went about her normal routine most of the morning. V9 stated, about 12:30 PM, when V10 Hospice Certified Nurse Assistant (CNA) came to V9 to inquire about R5's pain medicine, is when she realized she had given R5 an overdose of the Morphine earlier that morning. V9 stated she notified V1 Administrator and V2 Director of Nurses (DON) of her mistake. V9 stated all three of them (V1, V2, V9) went into R5's room right away. R5 was very difficult to arouse. V9 stated V1 asked her to get an order for Narcan (opioid antagonist) and administer the medication to R5. V9 stated she got the order, administered one dose of Narcan and within about 30 seconds R5 began to wake up and was confused as to why there were so many staff in her room. On 3/26/26 at 2:20 PM V10 Hospice Certified Nurse Assistant (CNA) stated she arrived at (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the facility to provide care for R5 on 3/10/26 at approximately 12:30 PM. V10 stated when she arrived R5 was sleeping. V10 stated when she asked R5 if she was in pain, R5 responded with a very quiet whisper, yes. V10 stated she left R5's room to talk to R5's nurse (V9 Registered Nurse). V10 stated she told V9 that R5 was in pain and asked if she could have more pain medicine. V9 went to check and came back stating she believed there was a mistake, and she had administered the wrong dose earlier that morning and therefore did not have any more morphine to give R5. V9 told V10 that R5 was given approximately 30 milliliters of Morphine Sulfate. V10 stated she called her Hospice Nurse (V21) and Hospice Director of Nurses (DON V19) to report the overdose. V10 stated she went back into R5's room and took her vital signs. V10 stated R5 was difficult to arouse, her eyes were fluttering open and closed, and she could not visually see R5 breathing so she had to place her hand on R5's chest to take her respiratory rate, which was very slow. On 3/27/26 at 10:39 AM V19 Hospice Director of Nurses (DON) stated she was called on 3/10/26 by V10 Hospice CNA who was concerned for R5's wellbeing. V10 told V19 that the facility had given R5 an overdose of Morphine and R5 was very drowsy and was very hard to wake up. V19 stated she had instructed V10 to take R5's vital signs while she was on the phone with her and V10 said it was hard to get R5's respiratory rate because her breaths were so shallow and slow. V10 had to place her hand on R5's chest to count any breaths. At that time R5's respiratory rate was decreased. On 3/26/26 at 2:06 PM V21 Hospice Registered Nurse stated V10 Hospice CNA called her to report R5 had received a significant overdose of Morphine that morning (3/10/26). V21 RN stated she went straight to the facility. She arrived at the facility at about 1:50 PM. R5 had just received one dose of Narcan. V21 stated V1 Administrator, V2 DON, and V9 RN as well as V10 CNA were in R5's room. V9 was taking R5's vital signs. V21 stated she remembers R5's respiratory rate was an eight (Breaths per Minute) at the time. R5 was very confused at the time and was not quite sure why everyone was in her room. On 3/26/26 at 12:21 PM V22 Hospice Licensed Practical Nurse stated she arrived at the facility on 3/10/26 at about 10:00 PM for a bedtime visit with R5. V22 stated she found R5 in her room in bed. R5 asked her for a drink of water but when V22 gave her the cup, R5 took a sip and then started to fall asleep while holding the water. V22 stated she took R5's vital signs and R5 had periods of apnea, and her respiratory rate was ten (Breaths per Minute). V22 stated R5's eyes rolled back in her head, and she wouldn't respond for a minute. V22 stated she consulted V21 Hospice DON and V29 R5's family who all agreed she should be sent to the emergency room. R5 was transferred to the emergency room for assessment after morphine overdose. On 3/27/26 at 11:47 AM R5 stated she remembered the morphine dose on the morning of 3/10/26 was a lot larger than normal. V9 RN put the Morphine in a medicine cup, and she usually got it in a little dropper under her tongue. R5 stated she wasn't sure maybe if the dose or medication changed but she took the medicine. R5 stated she remembers eating her breakfast that morning but doesn't remember anything after until V22 Hospice Nurse was telling her was going to the hospital, and she was confused as to why. R5 stated she knows they said she had a morphine overdose, and she knows she wasn't herself that day. R5 stated she can remember everything during and after the emergency room visit and everything before breakfast, but everything in between is just blank. R5 stated she is glad she is still alive. R5 stated she would not have wanted to die from someone's mistake. On 3/27/26 at 12:15 PM V25 Pharmacist stated an overdose of concentrated oral Morphine could results in shallow breathing, decreased respirations, impaired cognitions, and other effects up to or including death. On 3/27/26 at 3:44 PM V30 Hospice Medical Doctor confirmed a dose of 500 mg of oral Morphine is a high dose of Morphine and potential ramifications of this dose could be severe respiratory depression or death. On 3/20/26 at 1:05 PM V2 Director of Nurses confirmed V9 did not verify the inaccurate dose of Morphine or question the abnormally large dose of Morphine which led to V9 administering approximately 25 milliliters (500 milligrams) of oral Morphine Sulfate, which was an overdose Morphine for R5. R5's Hospital Transfer Form dated 3/10/26 documents R5 was transferred to the emergency room at 10:30 PM for periods of apnea and low respiratory rate. R5's Hospital Documentation dated 3/10/26 at approximately 11:00 PM, R5 arrived in the emergency room for (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	evaluation related to the morphine overdose. R5's Medication Error Report dated 3/10/26 documents there was a transcription error with R5's Morphine sulfate order. The dose was supposed to be 0.25 milliliters orally every two hours as needed however the order was transcribed as 30 milliliters orally every two hours as needed. The administering nurse (V9 RN) did not question order and administered 30 milliliters of Morphine Sulfate to R5. The report documents the error could have endangered R5 and had a high potential for adverse reactions up to and including death. The Immediate Jeopardy that began on 3/10/26 was removed on 3/10/26 when the facility had established R5 was clinically stable, administered Narcan (opioid analgesic) to R5, sent R5 to the emergency room for evaluation, and verified and corrected R5's medication order. The deficient practice was corrected on 3/11/26 after the facility took the following actions: 1.R5 was assessed clinically stable by V2 Director of Nurses. Completed 3/10/26. 2. V28 Medical Director was notified of the incident by V4 Assistant Director of Nurses. Completed 3/10/26. 3. R5 was given Narcan (opioid analgesic) and later sent to the local emergency room for evaluation on 3/10/26 at 10:30 PM. 4. V9 Registered Nurse was suspended pending a comprehensive investigation of the incident. Completed 3/11/26. 5. All licensed nursing staff were educated on proper protocol for medication order transcription, verifying order accuracy, double-check protocols, controlled medication administration documentation, medication error protocol, and who to notify for any medication discrepancy either in person or by phone by V2 Director of Nurses (DON) and V4 Assistant Director of Nurses (ADON). Completed 3/11/26. 6. The Medication Administration and Reconciliation Guidelines, Medication Administration Policy and the Controlled Substance Administration and Accountability Policy were reviewed and revised by V1 Administrator and V2 Director of Nurses. Completed 3/10/26. 7. A facility-wide audit of all controlled substance orders was completed by V2 Director of Nurses. Completed 3/10/26. 8.A facility wide audit of all high-risk medication transcription accuracy was completed by V2 Director of Nurses and V4 ADON. Completed 3/10/26. 9. A facility-wide audit was completed by the facility's pharmacy of all controlled substances in the building. Completed 3/13/26. 10. Ongoing Quality Assurance measures of random competency evaluations for nursing staff regarding high-alert medication administration for thirty days post incident completed by V2 Director of Nurses and V4 ADON. Started 3/11/26 and ongoing. 11. Ongoing Quality Assurance measures of random audits of medication administration techniques completed weekly for four weeks by V2 Director of Nurses and V4 ADON. Started 3/11/26 and ongoing, 12. Ongoing Quality Assurance measures of audits of controlled substance count sheets completed weekly for four weeks by V2 Director of Nurses and V4 ADON. Started 3/11/26 and ongoing. 13. Monthly review of medication error logs and follow up with the Quality Assurance Committee completed by V2 Director of Nurses and V4 ADON. Started 3/11/26. The facility presented an abatement plan to remove the immediacy on 3/31/26 and the survey team accepted the abatement plan on 4/1/26.