

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 04/28/2026
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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based upon interview, observation, and record review, the facility failed to promptly identify and intervene for an acute change in a resident's condition after a fall with a fracture; and failed to follow physician orders causing a delay in treatment that had the potential for harm for one (R4) of three residents reviewed on a sample list of seven residents. According to the Electronic Health Record (EHR) R4 has diagnoses including admission diagnosis of Urinary Tract Infection (UTI), Left Femur Fracture surgical aftercare, and repeated falls. R4's undated Care Plan documents R4 is high risk for falls with recent fall with fracture history (12/30/25); Interventions include adding scoop mattress on 1/26/26, offer to transfer R4 to wheelchair prior to dinner on 2/6/26, and non-skid strips placed by bed, and non-skid socks to replace slippers on 3/26/26. R4's Care Plan documents R4 is to ambulate with assistance and walker with left leg weight bearing as tolerated. R4 dependent on staff for ADL's, at risk for skin alterations, and has moderate cognitive impairment. and weaknesses. Facility Fall Log, undated, documents R4 had a fall on 2/6/26, and 3/26/26. Facility's Incident Final Report dated 4/1/26 documents that after staff and resident interviews, it was confirmed R4 had a fall event around 6:00 AM on 3/26/26. Per R6, R4's roommate, R4 transferred out of bed unassisted and appeared to be trying to make R4's way to R4's wheelchair which was by the closet. R4 made it about halfway when R4 suddenly slipped, falling onto R4's bottom. V15 Certified Nursing Aide (CNA) was alerted to the room by R6. V15 CNA reported V15 witnessed R4 seated on R4's buttocks in the middle of the room and had palms of both hands flat on the ground and was dressed in t-shirt, brief, socks and slippers. V15 CNA reported V15 assisted R4 from the floor and transported R4 to the nurse's station for observation. V2 DON interviewed R4 regarding the fall event. R4 reported R4 did have a fall a few days ago. R4 said R4 got up out of bed and was walking to get to R4's wheelchair when R4 slipped and fell on [R4's] butt and tried to stop [herself] with her hands. R4 reported that is how R4 broke her arm. R4 indicated R4 had put on R4's slippers prior to self-transferring and the fall event. V2 DON inspected the slippers and found them to have a very slick, faux-fur lined in-sole. There were no further witnesses to the fall event. On 4/22/26 at 11:40AM, R6 (R4's) roommate, stated R4 was trying to get from R4's bed to R4's wheelchair that was located by bathroom door. R6 stated R4 is supposed to call for help but didn't. R4 fell to ground and was complaining R4's wrist hurt. R6 stated R6 had to go into the hallway to get help and V15 CNA came into room and put R4 in R4's wheelchair and took R4 out of the room. On 4/22/26 at 11:43AM, R4 was observed in the dining room eating lunch meal. Left forearm and lower portion of left hand noted to have soft cast in place. Cast appeared to have lost shape and is very loose and hanging off R4's hand. On 4/22/26 at 11:45AM, V2 Director of Nursing (DON), confirmed V15 CNA got R4 up from floor without having a nurse assess R4 and did not communicate fall to nursing staff which lead to R4's wrist injury going unnoticed until the evening of the next day. V2 stated an investigation was started and V15 CNA, V16 Licensed Practical Nurse (LPN) and V17 LPN were all suspended pending investigation. V15 CNA received discipline for failure to report a fall, and all nursing staff were re-educated on fall procedures. V2 DON stated V2 was unaware R4 was still in a soft cast. V2 confirmed there was no documentation in R4's Electronic Medical Record (EMR) about R4 going to follow-up appointment. On 4/27/26 at 9:20AM, V8 Wound Registered Nurse (RN) stated that on 4/27/26 V8 was approached by a CNA wanting R4's arm (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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>assessed for unusual bruising. V8 stated initially V8 was told that R4 had not had any fall but later was told R4 fell out of bed. V8 stated V8 wrapped R4's wrist and reported bruising to V2 DON.R4's Radiology Report dated 3/27/26 documents R4 had an acute fracture of distal radius (Colles' fracture) and ulnar styloid process. Moderate degenerative changes. Osteopenia of the examined bones.R4's After Visit Summary dated 3/28/26 documents R4 was seen for closed fracture of the left wrist and to schedule follow up appointment with orthopedic surgery as soon as possible.On 4/22/26 at 1:00PM, V18 Ortho Surgery Office Tech stated R4 did not have any appointments scheduled and that the referral was closed after office staff attempted on 4/1/26 and 4/3/26 to contact facility to make an appointment. V18 stated no contact was ever made as phone number was not accurate. At 1:08pm, V18 informed this surveyor that the facility was currently on another line attempting to make an appointment for R4. At 1:09PM, V19 Ortho Advanced Practical Nurse (APN) stated that after reviewing R4's X-Rays, they most likely would not have recommended surgery due to R4's severe osteoporosis, however we would have either put R4 in a hard cast or appropriate immobilizing splint. V19 stated soft casts were made to be temporary only. V19 stated R4 will be seen tomorrow 4/23/26 and x-rays will be completed to assess fracture healing and alignment and make recommendations from there.On 4/23/26 at 10:27 AM, V20 Transportation Aide stated V20 makes all resident appointments and arranges transportation. V20 stated V20 will receive an email from V2 DON with resident information and appointment. V20 will then check EMR for order which V20 prints along with resident face sheet and faxes to appropriate medical office with two contact numbers to call with appointment time. V20 stated V20 follows up each fax request after two days with a phone call if V20 has not had a response. V20 stated V20 has a box for nursing to place orders with appointment requests during off hours.V20 stated that up until yesterday 4/22/26 V20 had no request or information regarding R4's need to see Orthopedic Surgery. V20 stated the order was written on a Saturday at 1:00AM, which would have been the nurse's responsibility to follow up and place information in transportation box.R4's Left Wrist X-Ray dated 4/22/26 documents interval healing of the mildly comminuted/impacted fracture of the distal left radius (wrist) with some callus formation evident about the fracture site. No evidence for dislocation. Positive ulnar variance with subacute fracture of the ulnar styloid (pinky finger side of wrist). Mild-moderate generalized osteoporosis (weak bones). Mild degenerative changes first carpometacarpal (CMC) joint (thumb joint). No radiopaque foreign body.On 4/23/26 at 2:41PM, R4 was observed returning to the facility from ortho appointment. Pink hard cast noted to left wrist/forearm. R4 stated R4 doesn't have any pain now but did in the other cast. R4 stated R4 is to return to doctor in a month.R4's After Visit Summary dated 4/23/26 documents R4 was seen for closed fracture of the left wrist with routine healing. Education for cast care enclosed and notice of next follow up appointment on 5/20/26 at 10:45AM.On 4/27/26 at 1:00PM, V2 DON stated the facility does not have a policy on following physician orders.R4's Progress Notes dated 3/27/26 documents the facility received abnormal X-ray results. Findings were reported to physician, who ordered that the resident be sent to the Emergency Department for treatment if unable to be seen by orthopedics immediately. R4's family was notified. An ambulance was called, and the resident was transported to hospital.R4's Progress Notes dated 3/28/26 documents R4 returned from hospital with soft cast in place to left forearm and referral to orthopedic surgery.Facility Incidents and Accidents Policy, undated, documents in the event of an incident or accident, immediate assistance will be provided, and any injuries will be assessed by the licensed nurse or practitioner, the affected individual will not be moved until safe to do so.Facility's Registered Nurse Job Description, undated, documents all nurses will transcribe physician orders to medical record and carry out orders as written.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based upon interview and record review the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that are complete and accurately documented for two residents (R3, R4) on a sample list of seven residents. 1) According to the Electronic Health Record (EHR) R3 has diagnoses including Cerebral Vascular Accident, Epilepsy, Vascular Dementia, Obstructive Uropathy, Severe Protein Malnutrition, Anxiety, and Autonomic Nervous System Disorder.R3's undated Care Plan documents R3 is dependent on staff for all Activities of Daily Living (ADL's), has indwelling nephrostomy and foley tubes, cognitive impairment is severe, has a seizure disorder, has a communication deficit related to Aphasia, is at risk to develop clinically unavoidable skin breakdown related to Cerebrovascular disease, history of loss of weight, and muscle weakness.R3's progress notes dated 4/9/26 documents R3 out of facility for procedure. R3's progress notes do not document R3 returning from procedure, any new medical devices, status, and new orders associated with procedure. R3's progress notes contain five 72-hour re-admission entries that are all blank. Next progress note entry was made by a nurse practitioner on 4/20/26 about a new infection.On 4/23/26 at 1:45 PM, V2 Director of Nursing (DON) stated that V2 was unclear why there are blank entries within R3's progress notes. V2 DON confirmed there are no follow-up progress notes documenting R3's return from R3's appointment on 4/9/26 and R3's clinical changes.2) According to the Electronic Health Record (EHR) R4 has diagnoses including admission diagnosis of Urinary Tract Infection (UTI), Left Femur Fracture surgical aftercare, and repeated falls.R4's undated Care Plan documents R4 is high risk for falls with recent fall with fracture history (12/30/25); Interventions include adding scoop mattress on 1/26/26, offer to transfer R4 to wheelchair prior to dinner on 2/6/26, and non-skid strips placed by bed, and non-skid socks to replace slippers on 3/26/26. R4's Care Plan also documents R4 is to ambulate with assistance and walker with left leg weight bearing as tolerated. R4 dependent on staff for ADL's, at risk for skin alterations, and has moderate cognitive impairment. and weaknesses.Facility Fall Log, undated, documents R4 had a fall on 2/6/26, and 3/26/26.R4's EMR does not document incident referred to as fall that occurred on 3/26/26 causing R4's injury, nor any physical assessment completed.R4's Progress Notes dated 3/27/26 documents R4 had bruising and swelling to left wrist. Physician notified and diagnostic testing ordered.On 4/22/25 at 11:45AM, V2 DON confirmed there was no documentation in R4's EMR about R4's fall on 3/26/26.The Facility's Documentation in Medical Record Policy, undated, documents each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.The Facility Incidents and Accidents Policy, undated, documents in the event of an incident or accident, documentation of the incident shall be entered within 24 hours of occurrence.</p>		