STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146084	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Bella of Morrison	500 North Jackson Street Morrison, IL 61270

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 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or arrange emergency care by a doctor 24 hours a day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a physician was overseeing the facility. This applies to all residents residing in the facility.The findings include:The facility provided a resident roster dated 11/22/25 which showed 36 residents residing at the facility.On 11/22/25 at 11:15 AM, this surveyor observed a note posted at the nursing station that showed, [The Medical Director] is on vacation 11/20 - 12/1 . DO NOT CALL OR TEXT - IF YOU NEED ASSISTANCE CALL THE OFFICE at [PHONE NUMBER]. A note was handwritten under the posting that showed, no one answers at this number, on any of the extensions and there is no option to leave a message with anyone but billing. [Administrator] and DON (Director of Nursing) are aware - unsure of the situation at this time. If any issues just send to ED (Emergency Department). Also, won't have any scripts (prescriptions) available. This posting showed it was faxed to the facility by the Medical Director's office. On 11/22/25 at 11:15 AM, V4 LPN (Licensed Practical Nurse) said, It has been an impossibility for a very long time to contact the physician. [The Medical Director] since the [new company] took over, has been very hard to communicate with. I have not had access to a physician since I don't know how long. I was told that we supposedly have to go through the DON and that only the DON can call the doctor. No effective communication for some time. I should be able to get ahold of someone if I need to talk to the physician. Now [the Medical Director] is on vacation and we can't call or text him. There is no one covering that I know of. If I needed to get ahold of a physician, I don't know what I could do. The note says to send out to the Emergency Department. If I need a prescription? (shrugged shoulders).On 11/22/25 at 1:07 PM, V1 (Administrator) said she does not know if the Medical Director is the physician for all residents in the facility. V1 said she did not know if anyone was covering for him while he was on vacation. V1 said she knows the medical director has a receptionist (V13) and she is working on figuring it out. V1 said she spoke with their company's Clinical [NAME] President, and she confirmed that the Medical Director does not have a Nurse Practitioner covering. On 11/22/25 at 1:45 PM, V1 said she spoke with the Medical Director's secretary (V13) and was told that even though he is on vacation, he has not provided coverage because he is still available to the nursing homes. V1 provided a copy of what was being posted at the nursing station after the previous posting was removed. The phone numbers provided on the new posting were different than the previous office number provided on the original posting. On 11/22/25 at 1:59 PM, V13 (Medical Director's Nursing Home Coordinator) said, He is still taking call. I have just told [V1] if for some reason, you cannot get ahold of him she could get ahold of me, and I could get ahold of him. I don't know why that note was faxed. They were supposed to let everyone know that he was going to be on vacation, I don't know why it said that it was supposed to say that he was on vacation and that it might take them longer to respond. There would have no way for them to get into contact with anyone at that phone number. I have no idea why they sent that. I think the girls were notifying that he was on vacation and out of the office, but they should have put on there that we have Nurse Practitioner to cover for him, if need be, during the day and after hours would still be the physician. I'm assuming the notice came from one of the two front office girls and it is completely incorrect.On 11/25/25 at 9:21 AM, V7 RN (Registered Nurse) said, . Notify physician of changes in (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

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F 0713 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition or if I need prescriptions written. I didn't have to send anyone out 911 during that time frame. I was already prepared though when I realized that [V14] was on vacation, and no one was there to contact. I would have contacted the Administrator and the Director of Nursing and told them I was using my nursing judgement and sending the resident out.On 11/25/25 at 9:49 AM, V5 LPN (Licensed Practical Nurse) said, . I tried to get ahold of [V14] the first day of his vacation because someone was wanting to discharge. I couldn't get ahold of anyone and couldn't leave any messages with any of the options except billing. I never got ahold of anyone. Generally, we contact them for abnormal vitals, falls, new admissions, and any concerns with medications. I tried every number I could find with no luck. The facility's policy and procedure revised 10/13/25 showed, Medical Director Responsibilities. Policy: the facility retains a physician designated as Medical Director, to coordinate the medical care provided by attending physicians, and to assist with the development and implementation of resident care policies. 2. The Medical Director will have his own caseload of residents as well as being available to oversee the medical care of all residents within the facility when other Attending Physicians are not available.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure nurses had access to the convenience medications and failed to ensure medications were available from the pharmacy for 2 of 3 residents (R1 and R3) reviewed for pharmacy services in the sample of 7.The findings include:1. R1's face sheet showed he was admitted to the facility 10/16/25 with diagnoses to include pneumonia due to other gram-negative bacteria, generalized anxiety disorder, malignant neoplasm of prostate, Alzheimer's Disease, and heart failure. R1's facility assessment dated [DATE] showed he had severe cognitive impairment and was dependent upon staff for all cares. R1's October 2025 Physician Order Sheet showed he was admitted with orders for buspirone, alprazolam, Cefdinir, Donepezil HCL, Doxycycline, furosemide, memantine, spironolactone, and tamsulosin. R1's October 2025 eMAR (electronic Medication Administration Record) showed the only medication he was administered for the first 48 hours after his admission was his melatonin. On 11/25/25 at 9:49 AM, V5 LPN (Licensed Practical Nurse) said, Switching over the pharmacy, it was taking several days to get medications, we were calling them and resending the orders. We did everything we could, I worked Saturday after his admission [DATE]) and none of [R1's] medications were here. I asked his wife if she had any of his medications she could just bring, but she was in such bad shape herself, I think she forgot before she even left here. The [electronic convenience medication cart] has Wi-Fi problems and disconnects all the time. We all know how to get in it but it hasn't been functioning at all. It hasn't been accessible. It's constantly having to be reset.On 11/22/25 at 11:15 AM, V4 LPN (Licensed Practical Nurse) said R1 was not at the facility very long. V4 said R1 was in a bad state of being during his stay. V4 said R1 was mostly nonverbal. He was 1:1 at times due to being very combative. V4 said medications are usually here the following day after admission but with the constant changing of ownership and pharmacy it has been terrible. V4 said, As of October 1, the facility ownership and pharmacy changed. V4 said R1's medications took quite a while to come in. V4 said she remember it taking a long time for R1's medications to arrive. V4 said the new pharmacy did bring an [electronic convenience medication cart] but the nursing staff cannot access it. V4 said she hasn't had time to even try and figure out the [electronic convenience medication cart] because she thinks it needs to be reset. V4 said she has only been able to access the [electronic convenience medication cart] one time since October 1. V4 said we really should have access to those medications for the residents. V4 said she didn't understand why, but there was a lot of confusion with the change-over. V4 said they used to have just boxes with convenience medications but now with the new company we have the electronic cart for those medications, and it doesn't seem to work. On 11/25/25 at 12:10 PM, V12 RN (Agency Registered Nurse) said, I would say there would at least one patient each time that I have worked that a resident didn't have medications. I questioned if I was able to access [electronic convenience medication cart] the for medications and I was told because I'm agency I didn't have access to it. as a seasoned agency nurse, that was one of my first questions when I started. I was informed then, by the nurse I received report from that I didn't have access to it. I had a conversation with the DON (Director of Nursing) and she confirmed that as well. I expressed concerns a few times. It is concerning to me because. because I would need it if a patient was prescribed a new medication or is out of medication. It would be standard of care. Standard rule of thumb, when a medication is missing, we would try and locate it, obviously we could possibly pull it from convenience medications.On 11/25/25 at 9:21 AM, V7 RN (Registered Nurse) said, . We always run out of prescriptions, with the new changes and the new company it has gotten worse. The new company took over October 1st and since then everything has been haywire. All the medications are late, and all the nurses would try to fill the medications, but the pharmacy isn't filling them. It isn't just the new prescriptions that are taking a long time, it's all the medications. When [R1] came in, the pharmacy was delayed for a few (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	days. He was not getting his medications because the pharmacy wasn't delivering his medications. All his medications took a while to come in. It wasn't because of the practitioner, and it was because of the nurses, it was because of the new pharmacy. With the previous pharmacy we were able to get medications from a convenience box. Now they got a [electronic convenience medication cart] that needs Wi-Fi__33. In [R1's] case we would have had to get the medications out of the [electronic convenience medication cart] and agency nurses don't have access to it. I heard it also wasn't up and running and wasn't working, then they had issues with logging in and Wi-Fi. I don't think that problem has been corrected. we were contacting the pharmacy constantly telling them we needed [R1's] medications. [R3] takes scheduled doses of Lactulose and that has been taking a long time to come in as well. She has been out of that frequently. On 11/25/25 at 10:01 AM, V11 (Facility's Pharmacist) said the first delivery of R1's medications to the facility occurred on 10/19/25 at 3:45 AM. The pharmacy's Packing Slip Proof of Delivery showed the 10/19/25 delivery included R1's following medications: buspirone, donepezil, doxycycline, furosemide, hydrocortisone cream, ibuprofen, ketoconazole cream, and memantine. V11 said R1's Cefdinir (antibiotic) and Alprazolam (antianxiety medication) was delivered to the facility 10/20/25 at 2:43 AM and R1's antibiotic eye drops were delivered to the facility 10/21/25 at 3:21 AM. On 11/25/25 at 1:18 PM, V1 (Administrator) said, We have had some delay when we first got the new pharmacy. It is not typical. We had the convenience box from previous pharmacy and then the new pharmacy took over and brought [an electronic convenience medication cart]. Many medications are available in the [an electronic convenience medication cart]. If a medication is not in the cart, I would expect the nurses to call the pharmacy and get the medication out. V1 said she was not aware there were issues getting the [electronic convenience medication cart] to work or that the agency nurses were unable to access the convenience cart. V1 said the facility's agency nurses should have access to the convenience medications for the residents. 2. R3's face sheet showed she was admitted to the facility 12/2/2014 with diagnoses to include dementia without behavioral disturbance, schizophrenia, anxiety disorder, major depressive disorder, hypothyroidism, slow transit constipation, insomnia, and chronic kidney disease. R3's facility assessment dated [DATE] showed she has no cognitive impairment. On 11/22/25 at 9:22 AM, R3 said, . Sometimes they are out of my medications. The most recent one I have trouble with is my laxative that I need to take. Some of the nurses will replace it with a different laxative. It does affect me if I don't take it, I get constipated.R3's November 2025 eMAR (electronic Medication Administration Record) showed on 11/9/25, R3's Lactulose was not available at this time and on 11/13/25, R3's Potassium Chloride and Nortriptyline was unavailable. The facility's policy and procedure with review date of 10/13/25 showed, Medication Administration. Policy: Medications are administered by licensed nurses. as ordered by the physician and in accordance with professional standards or practice. 1. Keep medication cart clean, organized, and stocked with adequate supplies.The facility's policy and procedure reviewed 10/13/25 showed, Unavailable Medications. This facility shall use uniform guidelines for unavailable medications. 1. This facility maintains a contract with a pharmacy provider to supply the facility with routine, prn (as needed), and emergency medications. 2. A STAT (as soon as possible) supply of commonly used medications is maintained in-house for timely initiation of medications. 3. The facility shall follow established procedures for ensuring residents have a sufficient supply of medications. 4. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: a. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. B. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold.The facility's policy and procedure reviewed 7/18/18 showed, . Emergency Pharmacy Service and Emergency Kits, Policy: Emergency pharmacy service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved Emergency (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication Kit/Box or by special order from [the pharmacy]. [The pharmacy] supplies emergency medications including emergency drugs, antibiotics, controlled substances. to serve the immediate clinical needs of the residents.

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was free of significant medication errors for 1 of 3 residents (R1) reviewed for medication administration in the sample of 7. This failure resulted in R1 requiring 1:1 supervision related to increased restlessness and agitation and resulted in R1 not receiving prescribed antibiotics and being readmitted to the hospital with pneumonia. The findings include: R1's face sheet showed he was admitted to the facility 10/16/25 with diagnoses to include pneumonia due to other gram-negative bacteria, generalized anxiety disorder, malignant neoplasm of prostate, Alzheimer's Disease, and heart failure. R1's facility assessment dated [DATE] showed he had severe cognitive impairment and was dependent upon staff for all cares. R1's October 2025 Physician Order Sheet showed he was admitted with orders for buspirone, alprazolam, Cefdinir, Doxycycline, and furosemide. R1's Care Plan initiated 10/17/25 showed, [R1] has an eye infection, Neomycin-Polymyxin-Dexamethasone Ophthalmic Ointment. Instill 1 application in both eyes three times a day for reduce redness, swelling, or itching. Infection will be resolved without complications. Give therapeutic ointments, drops as ordered by physician.R1's October 2025 eMAR (electronic Medication Administration Record) showed R1 missed doses of his antibiotic ointment for his eye infection, Neomycin-Polymyxin-Dexamethasone Ophthalmic Ointment on 10/16/25, 10/17/25, 10/18/25, 10/19/25, and 10/20/25. R1's Care Plan initiated 10/17/25 showed, [R1] has bacterial pneumonia he takes doxycycline and Cefdinir for 4 days. [R1] pneumonia will be resolved without complications. Give medications as ordered.R1's October 2025 eMAR showed R1 missed doses of his antibiotic, Cefdinir on 10/16/25, 10/17/25, 10/18/25 and 10/19/25 (7 doses). R1's Care Plan initiated 10/17/25 showed, [R1] is on diuretic therapy Lasix (furosemide) and Spironolactone related to edema and hypertension. Administer diuretic medications as ordered by physician. R1's October 2025 eMAR showed R1 missed doses of his diuretic furosemide and spironolactone on 10/16/25 and 10/17/25.R1's Care Plan initiated 10/17/25 showed, [R1] uses anti-anxiety medications Xanax (Alprazolam) and Buspirone. the resident will be free from discomfort or adverse reactions related to antianxiety therapy through the review date. Administer antianxiety medications as ordered by physician.R1's October 2025 eMAR showed R1 missed doses of his antianxiety medication, buspirone on 10/16/25, 10/17/25, and 10/18/25 (5 missed doses). The same eMAR showed R1 missed doses of his antianxiety medication, alprazolam on 10/16/25, 10/17/25, 10/18/25, and 10/19/25 (7 missed doses). On 11/25/25 at 10:01 AM, V11 (Facility's Pharmacist) said the first delivery of R1's medications to the facility occurred on 10/19/25 at 3:45 AM. The pharmacy's Packing Slip Proof of Delivery showed the 10/19/25 delivery included R1's following medications: buspirone, doxycycline, and furosemide. V11 said R1's Cefdinir (antibiotic) and Alprazolam (antianxiety medication) was delivered to the facility 10/20/25 at 2:43 AM and R1's antibiotic eye drops were delivered to the facility 10/21/25 at 3:21 AM. On 11/22/25 at 11:15 AM, V4 LPN (Licensed Practical Nurse) said, [R1] was in a really bad state of being. [R1] was mostly nonverbal. He was 1:1 at times due to being very combative. I was told in report that he was in a bed that was low to the floor, he was constantly hitting and kicking, and trying to get ahold of staff but because of his condition he was not very successful with that.On 11/25/25 at 9:21 AM, V7 RN (Registered Nurse) said, [R1] was very anxious, he was combative, and it was very hard to communicate with him and calm him down. They had him on 1:1 due to his agitation, anxiety, and combativeness. He would kick and hit if you got too close. Once the alprazolam and buspirone were onboard, it helped. That is why he was a 1:1, we were contacting the pharmacy constantly telling them we needed these. On 11/25/25 at 12:05 PM, V10 (Previous CNA Supervisor) said, [R1] was 1:1 due to increased behaviors. He was a very high fall risk. He became agitated from time to time. He would yell out and become combative at times. On 11/25/25 at 1:18 PM, V1 (Administrator) said, I started [R1] on the one-on-one supervision because when he first arrived, he was trying to climb out of the chair and out of the bed, I didn't want him to (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	fall and get hurt. He had trouble communicating. I started it for safety. It started the day he came because of him climbing out of everything. R1?s Nursing Progress Note dated 10/26/25 at 6:13 PM showed, Resident was sitting up in broda chair next to nurse's station, napping off and on comfortably. No issues. CNA (Certified Nursing Assistant) came to this Nurse stating resident's wife came and took him in his broda chair into his room and was giving him drinks of water while he was lying back in the broda. Upon entering the room this Nurse saw the wife sitting beside resident with a cup of water on the bed stand next to them. The wife/POA began saying how the resident has been coughing all day and that she only gave him water because he was thirsty. This Nurse observed no coughing issues during the 2 hours I was around the resident. POA/wife wanted to call 911 because she knows he has Pneumonia I told her that was her choice if she wanted him to be evaluated. VS taken (blood pressure) 90/60 (Pulse) 64 (Respirations)18 Temperature 97.8 SPO2 88% on room air. Call to 911 was placed. R1's Nurse Progress Note dated 10/27/25 at 1:00 AM showed, Writer called [local acute care hospital] and spoke to ER (Emergency Room) nurse. the resident is admitted for pneumonia.The facility's policy and procedure revised 10/1/25 showed, Medication Errors. Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safety in an environment free of significant medication errors. Medication Error means the observed or identified preparation or administration of mediations of biologicals which is not in accordance with the prescriber's order. Significant medication error means one which causes the resident discomfort or jeopardizes his/her health and safety. 1. The facility shall ensure medications will be administered as follows: a. According to physician's orders. c. In accordance with accepted standards and principles which apply to professionals providing services. 4. The facility will consider factor indicating error in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with the prescriber's order. Examples include, but not limited to: . Medication omission.