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Form Approved OMB
No. 0938-0391

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	02/24/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review the facility failed to honor and implement a resident's DNR (do not resuscitate) status as indicated per the resident's POLST form (Physician Orders for Life-Sustaining Treatment form) for 1 of 3 residents (R5) reviewed for advance directives in the sample of 7.The findings include:R5's admission record showed R5 was admitted to the facility, from a local hospital, on 2/10/26. R5's hospital discharge orders dated 2/10/26 showed R5 was a DNR. R5's admission care plan dated 2/10/26 showed R5 was cognitively impaired. R5's care plan showed no documentation related to R5's advanced directives. R5's healthcare Power of Attorney (POA) form dated 12/8/25 showed V15 was R5's POA. A POLST form dated 2/20/26 showed R5 was a DNR.On 2/24/26 at 10:23 AM, V15 (R5's POA) stated, (R5) is supposed to be a DNR. They (facility) have a signed POLST form showing this, but they said they couldn't honor the form until their (the facility's) medical director signs off on the DNR. That doesn't make sense.A physician order dated 2/12/26 showed R5 was a Full Code. On 2/24/26 at 10:53 AM, V2 Director of Nursing (DON) stated if a resident's POLST form shows a resident is a DNR, the facility is to honor the resident's request. V2 stated if the resident already has a POLST form signed by a physician, the facility's medical director does not also need to sign off on the form for the form to be valid. V2 reviewed R5's POLST form, hospital discharge orders, and current admission orders. V2 stated, I don't know why he (R5) is a Full Code. He should be a DNR. The facility's Residents' Rights Regarding Treatment and Advance Directives policy dated 10/13/25 showed, It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate advance directives. Upon admission, should the resident have an advance directive, copies will be made and placed in the chart as well as communicated to the staff. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide incontinence care to residents dependent on staff for cares for 2 of 4 residents (R1, R2) reviewed for activities of daily living (ADLs) in the sample of 7. The findings include:1.R1's resident assessment dated [DATE] showed R1 was cognitively impaired and was dependent on staff for toileting and incontinence care. On 2/23/26 at 10:24 AM, V6 (R1's private caregiver) stated she visits R1 daily in the facility. V6 stated, They don't toilet (R1) or change her brief unless I ask them too. She will sit in the same brief for hours.On 2/23/26 at 8:28 AM, R1 was dressed and seated in the dining room eating breakfast. V4 Certified Nursing Assistant (CNA) stated she had last changed R1's incontinence brief around 7:00 AM that morning, prior to getting her dressed for the day.On 2/23/26 at 9:13 AM, R1 was moved from the dining room to the activity room by facility staff. On 2/23/26 at 9:45 AM, R1 remained seated in her wheelchair in the activity room.On 2/23/26 at 10:00 AM, R1 remained seated in the activity room. V6 (R1's private caregiver) was seated next to R1.On 2/23/26 at 11:10 AM, R1 remained seated in the activity room with V6 seated next to R1. On 2/23/26 at 12:07 PM, R1 was in her room with V6. V6 stated, I have been here since 10:00 AM. No one has offered to toilet or change her since I have been here. On 2/23/26 at 12:37 PM, R1 was transferred into bed by V4 and V11 CNAs. V11 removed R1's incontinence brief. V4 stated R1's brief has not been changed since 7:00 AM (over 5 hours). R1 was incontinent of urine. R1's buttocks were red. 2.R2's resident assessment dated [DATE] showed R2 was severely cognitively impaired and dependent on staff for toileting and incontinence care. The assessment showed R2 was incontinent of stool and urine.R2's current care plan showed, Check resident every two hours and assist with toileting as needed due to R2's incontinence. On 2/23/26 at 8:32 AM, R2 was seated in a wheelchair in her room. An odor of stool was noted in the room. V8 CNA stated R2's incontinence brief was last changed by facility night staff; sometime before 5:00 AM (at least 3.5 hours prior). V8 stated, When I got here at 5:00 AM, (R2) was already up and dressed for the day. V8 and V11 CNAs transferred R2 into bed and removed R2's incontinence brief. R2 was incontinent of a large amount of liquid stool. R2's buttocks appeared bright pink. On 2/24/26 at 10:53 AM, V2 Director of Nursing stated residents that require staff assistance with toileting and/or incontinence care are to be toileted and/or provided with incontinence care every 2 hours and as needed. The facility's Incontinence policy dated 10/13/25 showed, Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, interview and record review the facility failed to provide daily wound treatments to a resident's leg laceration for 1 of 3 residents (R1) reviewed for wounds in the sample of 7.The findings include:R1's progress notes and hospital records dated 1/23/26 showed R1 sustained a laceration to her left lower leg while being transferred into bed by facility staff. R1 was emergently transported via ambulance to a local hospital for an evaluation of her laceration. R1's leg laceration was repaired with nine (9) sutures. R1 was discharged back to the facility with orders for facility staff to provide daily wound treatments and dressing changes to R1's laceration.On 2/23/26 at 10:24 AM, R1 was seated next to V6 (R1's private caregiver) in the activity room. A gauze dressing was noted around R1's left lower leg. No date was noted on the dressing. V6 stated, Every day, I have to ask them (facility staff) to change her leg dressing. There were two days, on February 11 and 12th, they didn't change her dressing at all.On 2/23/26 at 2:00 PM, this surveyor reviewed R1's February 2026 Treatment Administration Record (TAR). A physician order dated 2/7/26 showed, Cleanse wound to LLE (left lower extremity) with wound cleanser. Cover with xeroform (bandage), maxorb (bandage), abdominal pad, and wrap with kerlix dressing, every day shift. The TAR showed no documentation that wound treatments and dressing changes were provided to R1's wound on 2/11/26 or 2/12/26. On 2/24/26 at 8:51 AM, R1 was seated in her wheelchair next to V6 (R1's private caregiver). The gauze dressing around R1's left lower leg appeared dirty with a moderate amount of yellow drainage noted on the undated dressing. V6 stated, I was here until 7:00 PM last night. No one changed her dressing yesterday. On 2/24/26 at 10:00 AM, this surveyor again reviewed R1's February 2026 TAR. The TAR showed no wound treatment or dressing change was provided to R1's left leg wound on 2/23/26. The TAR showed new documentation, from V2 Director of Nursing (DON), that V2 had provided wound care and a dressing change to R1's leg wound on 2/11/26 and 2/12/26. On 2/24/26 at 10:53 AM, V2 DON stated resident wound care treatments and dressing changes are to be completed, as ordered, by facility nursing staff. V2 stated only the nurse completing the wound care can document that the care had been provided in a resident's electronic medical record. When V2 was asked if she provided wound care to R1's leg laceration on 2/11/26 and 2/12/26, as per the new documentation noted on R1's February 2026 TAR, V2 stated, No, I didn't do her wound care on those days. I was always told by corporate to never leave that charting blank so when I saw (R1's) TAR was blank on those dates, I put my initials on those dates in her chart last night.The facility's Wound Treatment Management policy dated 10/13/25 showed, Wound Treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review the facility failed to safely transfer residents and in a manner to prevent resident falls and injuries for 2 of 5 residents (R1, R3) reviewed for resident safety and supervision in the sample of 7. This failure resulted in R1 sustaining a large leg skin laceration, during a transfer, that required emergent transport to a local hospital for suture repair. The findings include:1.R1's progress notes and hospital records dated 1/23/26 showed R1 sustained a laceration to her left lower leg while being transferred into bed by facility staff. R1 was emergently transported via ambulance to a local hospital for an evaluation of her laceration. R1's leg laceration was repaired with nine (9) sutures. R1 was discharged back to the facility on antibiotics for the laceration and with orders to follow up with the hospital's wound care team.R1's admission physical therapy evaluation dated 1/8/26 showed, Per consultation, patient demonstrated fear of falling as evidenced from patient getting anxious and unable to stand with 1 person assist despite max assistance given. Patient demonstrated severe posterior lean when attempted to stand. Patient was able to stand with CGA (contact guard assistance) of 2 people. The evaluation showed R1 required the assistance of 2 staff for transfers and standing. On 2/23/26 at 11:16 AM, V7 Certified Nursing Assistant (CNA) stated she was transferring R1, from her wheelchair to the bed, on 1/23/26 when R1's leg laceration occurred. V7 stated, It was my first time taking care of her, so I didn't know how she transferred. I went to stand her up and she started freaking out. She became frantic and panicked which made me anxious, so I just hurried up and got her on the bed. She immediately said her leg was hurting. I pulled up her pant leg and saw a big skin tear. My guess is that her leg got caught on the leg of the wheelchair when I was transferring her. I should have stopped and gotten someone else to help me move her. I should have given her time to calm down. On 2/23/26 at 2:19 PM, V12 Restorative Nurse stated to ensure R1's safety, R1 should be transferred by two staff due to her extreme anxiety and fear of falling. On 2/23/26 at 12:11 PM, V10 Medical Director stated staff are to transfer residents in accordance with the recommendations made by skilled therapy or restorative services. V10 stated his expectation is that residents are not injured while being cared for by staff. 2.R3's care plan dated 11/5/25 showed R3 had history of falls in the facility. R3 was at risk for falls due to her impaired cognition and the paralysis of her right arm and right leg due to a previous stroke. R3 was nonverbal. The plan showed R3 required the use of a gait belt and the assistance of one staff for transfers, standing, and ambulation. R3's fall incident report dated 1/27/26 showed R3 sustained a fall in her bathroom while being cared for by V4 CNA. R3 struck her head on the sink as she fell. R3 complained of right leg pain post-fall. R3 was emergently transported by ambulance to a local hospital for an evaluation. R3's hospital radiology studies were negative for any fractures or injuries. R3 was discharged back to the facility on 1/27/26. On 2/23/26 at 2:04 PM, V4 CNA stated on 1/27/26, she assisted R3 to a standing position, off the toilet, without using a gait belt. V4 stated, When I turned away from (R3) to take off my gloves and wash my hands, she fell to the ground. I wasn't holding onto her at all when she fell.On 2/23/26 at 2:19 PM, V12 Restorative Nurse stated staff are to use a gait belt when transferring R3. The facility's Use of Gait Belt policy dated 10/13/25 showed, It is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety.

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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 observation, interview and record review the facility failed to administer resident medications at the correct time and as per physician order. The facility failed to monitor a resident's blood glucose (sugar) level at the correct time and as per physician order. These failures apply to 1 of 3 residents (R5) reviewed for medication administration in the sample of 7.The findings include:R5's admission record showed R5 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus.On 2/24/26 at 10:23 AM, V15 (R5's Power of Attorney/POA) stated the facility had not been checking R5's blood glucose levels like they were supposed to. V15 also stated the facility had been giving R5 his medications late. R5's February 2026 Medication Administration Record showed the following orders for R5;Accu-checks (blood glucose monitoring) to be done before meals and at bedtime. R5's accu-checks to be done daily at 6:30 AM, 11:30 AM, 4:30 AM, 9:00 PM.Humulin R (regular insulin); inject 3 units subcutaneously (SQ) with meals at 7:30 AM, 12:00 PM, 5:30 PM.Reglan (medication for gastric reflux) 10 milligrams, give one tablet before meals at 6:30 AM, 11:30 AM, 4:30 PM.On 2/24/26 at 8:32 AM, R5 was seated in the dining room with his breakfast tray in front of him. R5 had consumed approximately 25% of his breakfast. R5 told nearby facility staff that he was done eating his meal. At 8:33 AM, V13 Licensed Practical Nurse (LPN) checked R5's blood glucose (after he had eaten). V13's blood glucose was 256. At 8:39 AM, V13 administered 3 units of Humulin R to R5 (over 2 hours late). At 8:56 AM, V13 administered 10 milligrams of Reglan to R5 (over 2 hours late and after R5 had eaten).On 2/24/26 at 10:53 AM, V2 (Director of Nursing) stated medications are to be administered at the scheduled time and as per physician order. V2 stated medication administration is considered late if the medication is given later than one hour past it's scheduled time. V2 stated, Residents blood sugars are to be checked prior to them eating so we have an accurate result. If a blood sugar is checked after a resident eats, the sugar will be high and not accurate. The facility's Blood Glucose Monitoring policy dated 10/13/25 showed, The facility will perform blood glucose monitoring as per physician's orders.The facility's Timely Administration of Insulin policy dated 10/13/25 showed, It is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition. All insulin will be administered in accordance with physician's orders.The facility's Medication Administration policy dated 10/13/25 showed, Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time d. Right documentation. Administer medications as ordered in accordance with manufacturer specifications.