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	02/22/2022

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to implement the facility's abuse prevention and reporting policy by failing to report an injury of unknown source to the state survey agency for one (R1) of three residents reviewed for injuries in the sample list of seven. Findings include: The facility's Abuse Prevention and Reporting-Illinois policy revised on 12/17/21 documents the following: For injuries not involving abuse or neglect, additional facts will be gathered to determine if the injury is an injury of unknown source. An injury is considered an injury of unknown source when the source of the injury is not observed or could not be explained by the resident, and the injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one point in time, or the number of incidents over time. The procedures and time frames for reporting and investigating abuse will be followed for an injury of unknown source. Allegations of abuse, neglect, exploitation, or mistreatment will be reported to the Department of Public Health no later than two hours after the allegation is made, or within 24 hours if the allegation does not involve serious bodily injury. A final investigative report will be sent to the Department of Public Health within five working days. On 2/16/22 at 10:53 AM V6 Licensed Practical Nurse (LPN) stated: R1 was sent to the hospital due to a situation with R1's G-tube (on 2/11/22). Later that same day, V6 received a phone call from an unidentified hospital physician to give an update on R1. The physician claimed that R1 told the hospital staff that R1 had fallen at the facility, and that R1 had a lacerated spleen and G-tube dislodgement. There was nothing passed on in report that R1 had fallen. V6 immediately notified V1 Administrator of the report. The facility's Concern/Compliment Form dated 2/11/22 documents: At 11:45 AM V1 Administrator spoke with V20 Hospital Nurse. V20 stated that R1 reported R1 had fallen sometime between when R1 had left the hospital yesterday (2/10/22) and returning to the hospital this morning. R1's gastrostomy tube was not in place and R1 had a ruptured spleen. No formal records were sent from the hospital. V1 spoke with night shift staff and R1's roommate (R3), and R1 did not fall at this facility. R1's injury is not listed on the facility's abuse log. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Nursing Notes document the following: R1 admitted to the facility on [DATE] at 7:16 PM. R1 is alert and oriented x 3 (person, place time.) On 2/11/2022 at 11:41 AM R1 complained of abdominal pain during flushing of R1's peg (percutaneous endoscopic gastrostomy) tube. There were 10 milliliters of serosanguineous residual and drainage around the stoma site. R1 was sent to the local emergency room for evaluation at 8:40 AM on 2/11/22. There is no documentation in R1's medical record or in the facility's incident/accident logs that R1 had an incident or fall resulting in R1's gastrostomy tube dislodgement or spleen injury. R2's Hospital Admission History and Physical dated 2/11/22 at 9:08 AM documents the following: While transferring patient (R1) fell down at the nursing home and since that time the G- tube (gastrostomy) could not be accessed and there was blood initially and also the patient has severe pain while injecting into the stomach. (R1) had a CT (Computed Tomography) of the abdomen that showed some splenic injury. This splenic injury was seen and the CT scan of February 3rd too. The patient had G-tube placement on 2/8/22 for failure to thrive. (R1) is being admitted for observation and possible G-tube replacement. R2's Hospital Clinical Consultation note dated 2/15/22 documents R1 admitted with a G-tube malfunction after a fall, and R1's G-tube was replaced. On 2/16/22 at 9:54 AM V1 stated: R1 had a new G-tube prior to admitting to the facility on [DATE]. R1 was in the facility for less than 12 hours. On 2/11/22 V1 spoke with V20 who reported that R1 had a lacerated spleen from a fall at the facility. R1 was admitted to the hospital with a G-tube dislodgement. V1 didn't consider R1's injuries to be an injury of unknown origin since R1 did not have a fall here in the facility. R1's spleen laceration was noted in R1's hospital records on 2/3/22, prior to when R1 admitted to the facility. On 2/16/22 at 12:34 PM V1 stated: On 2/11/22 at approximately 11:55 AM, V6 LPN reported to V1 that the hospital had called alleging R1's fall and injuries. V1 obtained R1's hospital records on 2/14/22 (3 days after R1's injuries were reported) that identified R1 had a spleen laceration prior to admission, on 2/3/22. V1 did not consider R1's G-tube dislodgement as a reportable injury. Staff and R3 were interviewed on 2/11/22. R1 had not been in the facility long enough to determine R1's cognitive status or if R1 is a good historian regarding R1's report of a fall. V1 did not report R1's injuries to IDPH since the information of R1's injuries were given verbally to V1. V1 had no proof that an incident occurred in the facility that caused R1's spleen laceration or G-tube dislodgement.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40385 Based on observation, interview, and record review the facility failed to implement a care plan intervention for a right arm sling for one (R2) of three residents reviewed for injuries in the sample list of seven. Findings include: R2's Admission Record documents on 2/9/22 R2 had a diagnosis of a nondisplaced comminuted right humerus shaft fracture. R2's Hospital Palliative Medicine Progress Note dated 2/8/22 at 10:00 AM documents: R2 is to wear a sling for comfort. R2's fracture is stable with a low chance of moving. R2's Care Plan dated 2/11/22 documents R2 has an acute cortical neck of humerus fracture following a fall. This care plan documents interventions for R2 to wear a sling when up and for comfort. There is no documentation that R2 refuses to wear the sling. On 2/16/22 at 8:58 AM R2 stated R2 fell three times about two weeks ago, in R2's room and in the shower room. R2 stated R2 hurt R2's leg and broke R2's right arm. On 2/16/22 at 10:51 AM R2 was asleep in a wheelchair in R2's room. R2 was not wearing a sling to R2's right arm. On 2/16/22 at 11:38 AM V4 Certified Nursing Assistant stated: R2 does not wear an arm sling, and R2 did not return from the hospital with a sling. V4 had gotten R2 up yesterday for a shower, and R2 wasn't wearing an arm sling. On 2/16/22 at 10:48 AM V2 Director of Nursing stated the treatment for R2's right humerus fracture includes wearing a sling and a follow up appointment with orthopedic physician. The facility's Comprehensive Care Plan policy revised on 11/17/17 documents: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to complete post fall assessments per facility policy for one (R5) of three residents reviewed for resident injury in the sample list of seven. Findings include: R5's Admission Record dated 2/22/22 documents R5 admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, weakness, and repeated falls. R5's MDS dated [DATE] documents R5 is frequently incontinent of bowel and bladder, requires extensive assistance of two staff for transfers, limited assistance of one staff person for walking, and extensive assistance of one staff person for toileting. R5's Care Plan revised on 1/12/22 documents (R5) is at risk for falls related to confusion, gait/balance problems, history of falls, poor communication/comprehension, psychoactive drug use, (and) unaware of safety needs. R5's Nursing Notes document the following: On 1/31/2022 at 10:39 PM R5 had a fall today, and has a wound to the back of R5's head. On 2/6/2022 at 9:05 PM documents R5's room mate came into the hall to report that R5 was on the floor. R5 was found sitting on the fall mat beside R5's bed. R5 was awake and talking in word salad per R5's norm. On 2/14/2022 at 2:20 PM R5 was found lying on R5's back in the hallway. R5 complained of a headache and there was a small amount of blood noted on the floor. R5 stated R5 was going to get coffee. R5's Unwitnessed Fall Incident Report dated 1/31/22 at 12:30 PM documents V5 LPN heard a resident across the hall yell out that R5 had fallen. R5 was found on the floor of R5's room. There was blood on the back of R5's head. R5 was alert, confused, and unable to give a description of the incident. R5's Fall Report dated 2/6/22 at 8:55 PM documents R7 (R5's room mate) came out into the hall to report that R5 had fallen. R5's Un-witnessed Fall Report dated 2/14/22 at 9:00 AM documents R5 was found on the floor in the lobby with bleeding and a hematoma to the back of R5s head. R5's Nursing Notes document post fall assessments on 1/31/22 at 10:39 AM, 2/3/22 at 10:42 AM, and 2/14/22 at 10:47 PM. There are no other documented post fall assessments completed for R5's falls on 1/31/22, 2/6/22, and 2/14/22. On 2/16/22 at 3:36 PM V2 Director of Nursing stated nurses should assess for range of motion and pain at the time of the fall, and post fall assessments are done every shift for 72 hours following the fall. V2 stated some nurses work 12 hour shifts, so the assessments are done at least twice a day. V2 stated the post fall assessments are documented in a progress note or under assessments in the electronic medical record. On 2/22/22 at 10:48 AM V2 Director of Nursing stated R5 is very confused and was trying to get up out of bed for the fall on 1/31/22. R5 was found on the floor in R5's room. V2 stated on 2/14/22 R5 had an unwitnessed fall and was found on the floor in the lobby. On 2/22/22 at 11:46 AM V2 stated R5 had an unwitnessed fall on 2/6/22 and was found on the floor of R5's room. On 2/22/22 at 1:25 PM V2 stated V2 had no additional documentation to provide for R5's post fall assessments.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to conduct thorough fall investigations to identify the root cause and develop/implement post fall interventions for two of three (R2, R5) residents reviewed for injuries in the sample list of seven residents. The facility failed to provide assistance with bathing in accordance with the resident's plan of care and resident assessment that resulted in R2 falling and sustaining a right humerus fracture and subdural hematoma (brain bleed). Findings include: 1. The facility's Report to IDPH (Illinois Department of Public Health) Regional Office dated 2/10/22 documents the following: R2 fell on [DATE]. On 2/3/22 R2 was found on the floor beside R2's bed. R2 stated R2 did not fall. R2 refused to go the emergency room for evaluation following the incidents. On 2/5/22 R2 had a change in condition and was admitted to the hospital with diagnoses of right humerus fracture and chronic subdural hematoma. R2's Minimum Data Sets (MDS) dated [DATE] and 1/14/22 document R2 is cognitively intact and requires physical assistance of one staff with bathing. R2's Care Plan revised 12/6/21 documents R2 has an ADL (Activities of Daily Living) self-care deficit with an intervention that R2 is able to shower R2's self with prompting and cueing. This care plan documents R2 is at risk for falls related to confusion, weakness, and impaired gait/balance with an intervention dated 1/28/22 to supervise at all times when taking a shower. This care plan does not document post fall interventions for R2's additional falls on 1/28/22 and 2/3/22. R2's Nursing Note dated 1/28/22 at 6:26 PM documents V3 Licensed Practical Nurse (LPN) was notified that R2 was on the floor. R2 was found lying prone (face down) on the floor. R2 was assessed and complained of pain to R2's right shoulder and favored R2's right arm. The physician was notified, and x-rays were ordered. R2's Un-Witnessed Fall Incident Report completed by V3 documents R2 was set up for shower this morning, and the staff person (V4) left the shower room to obtain towels. Upon return, R2 was found lying on the floor. R2 stated R2 slipped when R2 stood up. R2's Fall Incident Report dated 1/28/22 at 10:40 PM documents R2 was found lying supine (face up) on the floor near the nurse's station. R2 had bruising to R2's jaw, that was from the prior incident, and no other injuries noted. This report documents R2 was last observed 10 minutes prior sitting in a chair near the nurse's station, and R2 had refused to allow staff to assist R2 to bed. R2 was educated prior to the fall that smoke breaks were over at 6:00 PM. This report does not document the root cause of R2's fall or what post fall interventions were implemented following this fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's Nursing Notes document on 2/3/22 at 12:45 PM R2 was stumbling while walking and refused to be sent to the local emergency room for evaluation. R2's Un-Witnessed Fall Incident Report dated 2/3/22 at 9:00 PM documents R2 was found lying on the floor beside R2's bed. R2 stated R2 had not fallen, and that R2 had laid down on the floor. R2 denied hitting R2's head and there were no injuries. This report does not document the root cause of R2's fall, or what post fall interventions were implemented. There is no documentation that staff were interviewed to determine when R2 was last observed or what R2 was doing prior to the fall. R2's Nursing Note by V18 LPN documents on 2/5/22 at 12:04 PM R2 was sent to the emergency room for fall follow up. R2 was sleeping in R2's chair and was minimally responsive. R2 was confused and emesis was found beside R2's bed. R2's Right Shoulder X-ray dated 2/5/22 at 2:12 PM documents Acute cortical fracture of the neck of the right humerus is noted. R2's head CT (Computed Tomography) dated 2/5/22 documents R2 has altered mental status and fell on e week ago. This CT documents There is evidence of chronic bilateral subdural hematomas. The right at the area of lateral ventricle measures 8.2 cm (centimeters) x (by) 0.5 cm. The left at the area of lateral ventricle measures 9.5 cm x 0.8 cm. At subcortical level, the right subdural hematoma measures 7.8 cm x 0.9 cm seen. The left measures 10 cm x 1.2 cm. R2's Hospital Intensive Care Unit History and Physical dated 2/5/22 documents: R2 was transferred to a local hospital due to multiple falls in the last week. R2 was then transferred to this hospital for a neurosurgery consult. R2's active diagnoses include acute subdural hematoma and right humeral fracture status post fall. On 2/16/22 at 8:58 AM R2 was lying in bed. R2 stated R2 fell three times about two weeks ago, in R2's room and in the shower room. R2 stated R2 hurt R2's leg and broke R2's right arm. R2 stated R2 was showering by R2's self when R2 fell and hit R2's head. On 2/16/22 at 10:09 AM V3 LPN stated the following: On 1/28/22, V4 Certified Nursing Assistant (CNA) was assisting R2 in the shower. V4 had left the shower room to obtain towels, and left R2 unattended. V4 returned to the shower room and found R2 lying on the floor. V3 assessed R2 and R2 complained of right arm pain. R2 was not able to fully raise R2's right arm above R2's head. Prior to the fall, R2 needed limited assistance with bathing, but would refuse to let staff help R2. On 2/22/22 at 9:10 AM V4 stated: The day that R2 fell in the shower, R2 had asked V4 if R2 could take a shower. V4 let R2 into the shower room and left to go get towels, leaving R2 unattended. V4 returned and found R2 lying on the floor. R2 denied hitting R2's head and complained of right arm pain. R2 was independent with bathing prior to the fall, so V4 didn't stay in the shower room with R2. On 2/16/22 at 4:02 PM V17 Assistant Director of Nursing confirmed R2's 11/18/21 and 1/14/22 MDSs document R2 requires physical assistance of one staff person for bathing. On 2/22/22 at 9:26 AM V19 Care Plan Coordinator stated prior to R2's fall on 1/28/22, R2 used supervision assistance for bathing. R2 needed cues/reminders for bathing. If the resident requires supervision for bathing, staff should stay in the shower room with the resident during the shower. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/22/22 at 10:48 AM V2 stated: R2 fell twice on 1/28/22, about 10-15 minutes apart. For the first fall on 1/28/22 R2 was in the shower, and V4 had left R2 in the shower room to go get towels. When V4 returned, R2 was lying on the floor. The root cause was that R2 wasn't wearing any shoes and the floor was wet. The post fall intervention was staff are to stay in the shower room with R2 during the shower. R2 had previously refused to let staff be in the shower with R2, and refusals would be documented in a progress note. V4 was educated verbally to use the call light if V4 needs something, rather than leave a resident in the shower room. For the second fall on 1/28/22 R2 was found on the floor near the nurse's station/smoking entrance. We thought it was more of a behavior since R2 likes to smoke and likes to be the first one out to smoke. On 2/3/22 R2 was found on the floor of R2's room. R2 told staff that R2 laid down. We didn't consider it to be a fall since R2 has a BIMS (Brief Interview for Mental Status) of 13 (cognitively intact). We determined the root cause to be a behavior. Post fall interventions are documented on the care plan. On 2/22/22 at 11:46 AM V2 stated R2's post fall intervention for 2/3/22 fall was to collect a urine sample. The intervention for the second fall on 1/28/22 was R2 was educated on the need to wait for staff assistance to smoke. This should be documented on the incident report or progress note. V2 stated R2's injuries are believed to be related to one of R2's falls, and V2 was not sure which fall caused the subdural hematoma and right arm fracture. V2 stated R2 began to complain of right arm pain after the fall in the shower, but R2 denied hitting R2's head for the falls. On 2/22/22 at 12:50 PM V2 confirmed R2's care plan does not document post fall interventions for R2's second fall on 1/28/22, and fall on 2/3/22. V2 was unable to provide documentation that R2 refused to allow staff assistance for bathing on 1/28/22. 2.) R5's Admission Record dated 2/22/22 documents R5 admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease, weakness, and repeated falls. R5's MDS dated [DATE] documents R5 is frequently incontinent of bowel and bladder, requires extensive assistance of two staff for transfers, limited assistance of one staff person for walking, and extensive assistance of one staff person for toileting. R5's Care Plan revised on 1/12/22 documents (R5) is at risk for falls related to confusion, gait/balance problems, history of falls, poor communication/comprehension, psychoactive drug use, (and) unaware of safety needs. This care plan documents interventions dated 1/31/22 for a mattress to be placed next to R5's bed, 2/6/22 for a scoop mattress for R5's bed, and 2/15/22 for a protective helmet. R5's Nursing Notes document the following: On 1/31/2022 at 10:39 PM R5 had a fall today and has a wound to the back of R5's head. On 2/6/2022 at 9:05 PM documents R5's roommate came into the hall to report that R5 was on the floor. R5 was found sitting on the fall mat beside R5's bed. R5 was awake and talking in word salad per R5's norm. On 2/14/2022 at 2:20 PM R5 was found lying on R5's back in the hallway. R5 complained of a headache and there was a small amount of blood noted on the floor. R5 stated R5 was going to get coffee. On 2/14/22 at 10:47 PM there was a hematoma that measured 6cm x 4cm to the back of R5's head. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R5's Unwitnessed Fall Incident Report dated 1/31/22 at 12:30 PM documents V5 LPN heard a resident across the hall yell out that R5 had fallen. R5 was found on the floor of R5's room. There was blood on the back of R5's head. R5 was alert, confused, and unable to give a description of the incident. R5's Fall Report dated 2/6/22 at 8:55 PM documents R7 (R5's roommate) came out into the hall to report that R5 had fallen. These reports do not document interviews were conducted with staff or residents. There is no documentation of the last time R5 was checked on or toileted, or what R5 was doing prior to the fall. R5's Un-witnessed Fall Report dated 2/14/22 at 9:00 AM documents R5 was found on the floor in the lobby with bleeding and a hematoma to the back of R5s head. R5 stated R5 was going to get coffee and wasn't sure what happened. There is no documentation that staff or residents were interviewed regarding R5's fall. On 2/16/22 at 11:26 AM V5 Registered Nurse stated: On 2/14/22 R5 fell in the foyer and hit R5's head. Staff witnessed R5's fall. R5 had been in R5's wheelchair, had gotten up and fell . R5 was attempting to get coffee, but R5 had coffee and R5's meal tray at the table where R5's wheelchair was. On 2/22/22 at 10:48 AM V2 stated the fall reports are the facility's fall investigations. V2 confirmed there was no other documentation to provide for R2's and R5's fall investigations. V2 stated when staff call to report resident falls to V2, V2 asks the staff questions such as when the resident was last observed and toileted. V2 stated V2 does not document the interviews. V2 stated R5 is very confused and was trying to get up out of bed for the fall on 1/31/22. R5 was found on the floor in R5's room. The root cause of R5's fall was that R5 was getting more restless and having increased confusion. The post fall intervention was to use a mattress on the floor beside R5's bed. V2 stated on 2/14/22 R5 had an unwitnessed fall and was found on the floor in the lobby. The root cause of R5's fall was that R5 was restless. A helmet was ordered as a post fall intervention. On 2/22/22 at 11:46 AM V2 stated: R5 had an unwitnessed fall on 2/6/22. R5 was found on the floor of R5's room after R5's roommate (R7) came out to alert staff. The root cause of the fall was due to R5's confusion, and the post fall intervention was a scoop mattress. The facility's Fall Prevention Program revised 11/21/17 documents the following: The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Care plan incorporates identification of all risk/issue; addresses each fall; interventions are changed with each fall, as appropriate; (and) preventative measures. Accident/Incident Reports involving falls will be reviewed by the Interdisciplinary Team to ensure appropriate care and services were provided and determine possible safety interventions. Fall interventions may include the following: observe residents approximately every 2 hours for safe positioning, provide care including toileting needs in accordance with the resident's care plan, and residents who require staff assistance will not be left alone after being assisted to bathe, shower or toilet.