STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000861	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
La Bella of Morrison	**500 NORTH JACKSON STREET , MORRISON, Illinois, 61270**

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S0000	Initial Comments Complaint Investigation # 25110162/2646801	S0000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)1) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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S9999	Continued from page 1 practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. These requirements are not met as evidenced by: 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 10/22/25 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).	S9999		

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S9999	Continued from page 2 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	S9999		

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S9999	Continued from page 3 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 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	S9999		

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S9999	Continued from page 4 following: a. Medication administered not in accordance with the prescriber's order. Examples include, but not limited to: … Medication omission…" (A)	S9999		