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 12/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments First Probationary Licensure Survey	S0000		
S9999	Final Observations Statement of Violations: 1 of 19 300.625c)1) 300.625c)2) Section 300.625 Identified Offenders c) If the results of a resident's criminal history background check reveal that the resident is an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following: 1) Immediately notify the Department of State Police, in the form and manner required by the Department of State Police, that the resident is an identified offender. 2) Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. The inquiry shall be based on the subject's name, sex, race, date of birth, fingerprint images, and other identifiers required by the Department of State Police. The inquiry shall be processed through the files of the Department of State Police and the Federal Bureau of Investigation to locate any criminal history record information that may exist regarding the subject. The Federal Bureau of Investigation shall furnish to the Department of State Police, pursuant to an inquiry under this subsection (c)(2), any criminal history record information contained in its files. This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure a resident who was identified as an identified offender was fingerprinted and reported to the Illinois Identified Offender Program (IOP). This	S9999		

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

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 12/16/2025

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S9999	Continued from page 1 applies to 1 of 7 residents (R5) reviewed for identified offenders in the sample of 17. The findings include: The Illinois Department of Public Health (IDPH) identified offender program facility report provided by IDPH prior to the survey does not show R5 listed as a current resident residing in the facility as an identified offender. The identified offender list provided on 12/15/25 by the facility of current residents residing in the facility as identified offenders lists R5. R5's face sheet shows, she was admitted to the facility on 8/5/25. R5's Illinois State Police (ISP) background check done on 8/4/25 shows, she had a HIT with qualifying offenses. R5's background check and UCIA (Uniform Conviction Information Act) fingerprints were done and submitted to the IOP on 8/14/25. On 12/16/25 at 10:06 AM, V1 Administrator stated, R5's fingerprints and information was reported to the IOP (4 months ago). She has not received any information since. She has not followed up to find out what is taking so long. On 12/16/25 at 10:45 AM, V15 IDPH identified offender program representative stated, R5's information was reported however, the facility did the wrong fingerprint (UCIA). R5 needs to have a fee-app (Fee Applicant Inquiry) fingerprint done in addition to the UCIA. The facility was emailed saying R5's information was rejected and they had 10 days to fix it. They have not received any additional information from the facility. On 12/16/25 at 11:32 AM, V1 Administrator stated, she never received an email and maybe it was sent to a different person. The facility's Illinois Identified Offenders Background Screening and Submission Procedure (no date) shows, "If the results of a resident's UCIA name-based criminal history background reveal that the resident is an identified offender, as defined in Section 1-114.01 of the Nursing Home Care Act, the facility shall, within 72 hours arrange for a Fee Applicant (FEAPP) fingerprint-based criminal history record inquiry from	S9999		

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S9999	Continued from page 2 a licensed livescan vendor, using the FEAPP fingerprint consent form…." (C) 2 of 19 300.626c) Section 300.626 Discharge Planning for Identified Offenders c) When a resident who is an identified offender is discharged, the discharging facility shall notify the Department. This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to discharge a resident from the Illinois Identified Offender Program (IOP) following discharge. This applies to 1 of 1 resident (R17) reviewed for identified offenders in the sample of 17. The findings include: The Illinois Department of Public Health (IDPH) identified offender program facility report provided by IDPH prior to the survey shows, R17 is currently residing in the facility. The identified offender list provided on 12/15/25 by the facility of current residents residing in the facility as identified offenders does not list R17. R17's face sheet shows, he was admitted to the facility on 4/21/25 and discharged home on 9/15/25. On 12/16/26 at 10:06 AM, V1 Administrator stated, she has not reported to the IOP that R17 was discharged in the portal. The facility's Illinois Identified Offenders Background Screening and Submission Procedure (no date) does not show a procedure for when a resident who is an identified offender is discharged from the facility. The facility did not provide any other policies regarding the identified offender program. (C) 3 of 19 300.650c) 300.650d)	S9999		

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S9999	Continued from page 3 Section 300.650 Personnel Policies c) Prior to employing any individual in a position that requires a State license, the facility shall contact the Illinois Department of Financial and Professional Regulation to verify that the individual's license is active. A copy of the license shall be placed in the individual's personnel file. d) The facility shall check the Health Care Worker Registry for the work eligibility status of all applicants who are under the jurisdiction of the Healthcare Worker Background Check Act prior to hiring. These REQUIREMENTS were not met as evidenced by: Based on observation and interview the facility failed to verify a Licensed Practical Nurse (LPN) license with the Illinois Department of Financial and Professional Regulation prior to hire. The facility failed to check the Health Care Worker Registry prior to hire of a Certified Nursing Assistant (CNA). These failures have the potential to affect all 36 residents in the facility. The findings include: A facility roster dated 12/15/25 showed a resident census of 36. A facility staff roster printed on 12/15/25 showed V3 LPN was hired on 10/8/2025. V3's employee file showed V3's LPN license was not verified with the Illinois Department of Financial and Professional Regulation until 12/15/25. A facility staff roster printed on 12/15/25 showed V4 CNA was hired on 6/23/25. V4's employee file showed a background check on V4, via the Health Care Worker Registry, was not completed until 7/31/25. On 12/15/25 at 2:05 PM, V1 Administrator stated she was responsible for completing license and healthcare worker background checks on all new employees. V1 stated license verifications and background checks are to be completed prior to hiring employees. The facility's Background Investigations policy (undated) showed, "Job reference checks, drug screenings, licensure verifications and criminal conviction record checks are conducted on all personnel making application for employment with this company… For all applicants applying for position as a certified	S9999		

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S9999	Continued from page 4 nurse aide, the human resources department will contact the nurse aide registry of the state in which the individual is certified and/or previously employed to verify that the applicant's certification is in good standing…" The policy does not specify when these background checks and/or license verifications are to be completed by. (C) 4 of 19 300.661 Section 300.661 Health Care Worker Background Check A facility shall comply with the Health Care Worker Background Check Act [225 ILCS 46] and the Health Care Worker Background Check Code (77 Ill. Adm. Code 955). This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to conduct background checks for an employee within 10 days of being hired. This failure has the potential to affect all 36 residents in the facility. The findings include: A facility roster dated 12/15/25 showed a resident census of 36. A facility staff roster printed on 12/15/25 showed V4 Certified Nursing Assistant (CNA) was hired on 6/23/25. V4's employee file showed V4's background checks via the Illinois Sex Offender, Department of Corrections (DOC) Sex Offender, DOC Inmate Search, DOC Wanted Fugitive, National Sex Offender, and Office of the Inspector General websites were not completed until 7/31/25. On 12/15/25 at 2:05 PM, V1 Administrator stated she was responsible for completing healthcare worker background checks on all new employees. V1 stated background checks are to be completed prior to hiring employees. The facility's Background Investigations policy (undated) showed, "Job reference checks, drug screenings, licensure verifications and criminal conviction record checks are conducted on all personnel making application for employment with this company… For all applicants applying for position as a certified nurse aide, the human resources department will contact the nurse aide registry of the state in which the individual is certified and/or previously employed to verify that the applicant's certification is in good	S9999		

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S9999	Continued from page 5 standing…" The policy does not specify when these background checks and/or license verifications are to be completed by. (C) 5 of 19 300.670c) Section 300.670 Disaster Preparedness c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to: This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure fire drills were performed quarterly for each shift and failed to ensure disaster drills were performed twice annually for each shift. This has the potential to affect all 36 resident that reside in the facility. The findings include: The Resident Roster dated 12/15/25 shows that there are 36 residents residing at the facility. The Fire Drill Reports that were provided shows that fire drills were completed during the PM shift on 5/28/25 and 11/25/25. No other fire drills were performed on PM shift within the last year for PM shift. The Fire Drill Reports that were provided shows that fire drills were completed during the Night shift on 1/31/25, 7/30/25 and 9/25/25. No other fire drills for night shift were performed within the last year. A Tornado Drill was performed on 4/23/25 and 9/24/25 and were performed during the day shift. No other disaster drills were provided that were performed on PM and night shift. On 12/16/25 at 10:00 AM, V13 (Maintenance Director) said that fire drills are performed monthly and rotated by shift. V13 said that all shifts should have 4 drills a year. The facility's Fire Drill Policy shows, "Fire drills will be conducted monthly on rotating shifts under varied conditions and will be unannounced." (C) 6 of 19	S9999		

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S9999	Continued from page 6 300.830g) Section 300.830 Consultation Services g) The facility shall arrange for a consultant pharmacist as set forth in Section 300.1610. This REQUIRMENT was not met as evidenced by: Based on interview and record review the facility failed to have a signed contract with a pharmacy. This failure applies to all 36 residents. The findings include: The resident roster dated 12/15/25 shows, 36 residents residing in the facility. On 12/15/25 at 9:25 AM, R5 and R6 both stated, they have had issues with getting their medications since the change in ownership. On 12/16/25 at 8:32 AM, V5 Licensed Practical Nurse (LPN) stated, they have had lots of problems with pharmacy and getting medications since the change of ownership. On 12/16/25, V1 Administrator provided a pharmacy contract that was not dated or signed by either the facility or pharmacy. On 12/16/25, at the time of exit, the facility still had not provided a signed contract between the pharmacy and the facility. (B) 7 of 19 300.696d)14) Section 300.696 Infection Prevention and Control d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340): 14) Implementation of Personal Protective Equipment (PPE) in Nursing Homes to Prevent Spread of Novel or Targeted Multidrug-resistant Organisms (MDROs)	S9999		

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S9999	Continued from page 7 This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review the facility staff failed to wear personal protective equipment (PPE) when providing care to a resident on Enhanced Barrier Precautions (EBP) for 1 of 17 residents (R4) reviewed for infection control in the sample of 17. The findings include: R4's Care Plan shows that he is on EBP because he has a wound and interventions include: ensure PPE and alcohol based hand rub is readily available and accessible and use EBP during high contact care activities including changing briefs and wound care. On 12/15/25 at 1:26 PM, R4 had a sign on his room door that said that he was on EBP. V9 and V11 (Certified Nursing Assistants) transferred R4 into bed using a mechanical lift and provided incontinence care. V9 and V11 both did not have a gown on during the care. On 12/15/25 at 2:38 PM, V5 (Licensed Practical Nurse) performed a dressing change to R4's pressure wound on his left thigh. V5 did not have a gown on. On 12/15/25 at 2:46 PM, V2 (Director of Nursing) said that if a resident has a pressure wound, they should be on EBP and staff should wear PPE when providing incontinence care or dressing changes on them. The facility's Enhanced Barrier Precautions Policy shows, "Enhanced barrier precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities….An order for enhanced barrier precautions will be obtained for residents with any of the following…Wounds (e.g., chronic wounds such as pressure ulcers….High-contact resident care activities include:..Transferring…changing briefs…wound care.." (C) 8 of 19 300.1030d) Section 300.1030 Medical Emergencies d) When two or more staff are on duty in the facility, at least two staff people on duty in the facility shall have current certification in the provision of basic	S9999		

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S9999	Continued from page 8 life support by an American Heart Association or American Red Cross certified training program. When there is only one person on duty in the facility, that person shall be certified. Any facility employee who is on duty in the facility may be utilized to meet this requirement. This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure there were two staff members on duty in the facility who were certified in cardiopulmonary resuscitation (CPR). This failure has the potential to affect all 36 residents in the facility. The findings include: The facility's resident census reports dated 12/13/25 and 12/14/25 showed a resident census of 36. The facility's nursing schedules dated 12/13/25 and 12/14/25 showed V6 Licensed Practical Nurse (LPN), V4 Certified Nursing Assistant (CNA), V9 CNA, and V10 CNA were the only staff providing resident cares in the facility from 6AM-5 PM on those days. A facility list printed 12/16/25 showed V6 LPN, V4 CNA, V9 CNA, and V10 CNA were not certified in CPR. On 12/16/25 at 9:26 AM, the facility's December 2025 nursing schedule was reviewed with V2 Director of Nursing (DON). V2 stated she did not have any staff in the building that were CPR certified on 12/13/25 and 12/14/25 from 6 AM-5 PM. V2 stated the facility's goal is to have "1-2" staff members, that are CPR certified, in the building at all times in case of a resident emergency. On 12/16/25 at 11:43 AM, V1 Administrator stated the facility did not have a policy on CPR requirements for staff. (C) 9 of 19 300.1060a) 300.1060c) 300.1060d) 300.1060e) 300.1060f) 300.1060g)	S9999		

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S9999	Continued from page 9 Section 300.1060 Vaccinations a) A facility shall annually administer or arrange for administration of a vaccination against influenza to each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention that are most recent to the time of vaccination, unless the vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccinations for all residents age 65 and over shall be completed by November 30 of each year or as soon as practicable if vaccine supplies are not available before November 1. Residents admitted after November 30, during the flu season, and until February 1 shall, as medically appropriate, receive an influenza vaccination prior to or upon admission or as soon as practicable if vaccine supplies are not available at the time of the admission, unless the vaccine is medically contraindicated or the resident has refused the vaccine. (Section 2-213(a) of the Act) c) A facility shall administer or arrange for administration of a pneumococcal vaccination to each resident in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination or the vaccination is medically contraindicated. (Section 2-213(b) of the Act) d) A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, refused, or medically contraindicated. (Section 2-213(b) of the Act) e) A facility shall distribute educational information provided by the Department on all vaccines recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (available at: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf), including, but not limited to the risks associated with shingles and how to protect oneself against the varicella-zoster virus. The facility shall provide the information to each resident who requests the information and each newly admitted resident. The facility may distribute the information to residents electronically. (Section 2-213(e) of the Act)	S9999		

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S9999	Continued from page 10 f) A facility shall document in the resident's medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the resident was immunized against hepatitis B. (Section 2-213(c) of the Act) g) All persons determined to be susceptible to the hepatitis B virus shall be offered immunization within 10 days after admission to any nursing facility. (Section 2-213(c) of the Act) These REQUIREMENTS were not met as evidenced by: Based on interview and record review the facility failed to screen and offer residents the influenza, pneumococcal, and hepatitis B vaccines. The facility failed to screen residents for HIV and hepatitis C. These failures apply to 5 of 5 residents (R1, R2, R4, R5, R7) reviewed for vaccinations in the sample of 17. The findings include: R1's admission record showed R1 was admitted to the facility on 3/15/17. R1's immunization records printed 12/16/25 showed no documentation R1 had been screened for hepatitis B, hepatitis C, or HIV. The records showed no documentation of R1 ever receiving the hepatitis B vaccine. R2's admission record showed R2 was admitted to the facility on 12/5/25. R2's immunization record printed 12/16/25 showed no documentation R2 had been screened for or offered the influenza, pneumococcal, or hepatitis B vaccines. The records showed no documentation R2 had been screened for hepatitis C or HIV. R4's admission record showed R4 was admitted to the facility on 5/5/15. R4's immunization record printed 12/16/25 showed R4 had been screened for hepatitis B, hepatitis C, or HIV. The records showed no documentation of R4 ever receiving the hepatitis B vaccine. R5's admission record showed R5 was admitted to the facility on 8/5/25. R5's immunization record printed 12/16/25 showed no documentation R5 had been screened for or offered the pneumococcal or hepatitis B vaccines. The records showed no documentation R5 had been screened for hepatitis C or HIV. R7's admission record showed R7 was admitted to the facility on 11/21/24. R7's immunization record printed	S9999		

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S9999	Continued from page 11 12/16/25 showed no documentation R7 had been screened for or offered the pneumococcal or hepatitis B vaccines. The records showed no documentation R7 had been screened for hepatitis C or HIV. On 12/16/25 at 8:33 AM V7 Infection Preventionist stated residents are to be screened for and offered the influenza vaccine upon admission to the facility and annually, during flu season from “September to April.” V7 stated residents are to be screened for and offered the pneumococcal vaccine upon admission to the facility and “once a year if needed.” V7 it is the responsibility of the admission nurse to screen a newly admitted resident for these vaccines and administer them as needed. V7 stated the facility did not currently screen residents for hepatitis B, hepatitis C, or HIV. V7 stated the facility does not administer the hepatitis B vaccine series to residents unless specifically ordered by a physician. The facility’s Influenza Vaccine policy dated 10/13/25 showed, “Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine.” The facility’s Pneumococcal Vaccine policy dated 10/13/25 showed, “Each resident will be assessed for pneumococcal immunization upon admission… Each resident will be offered a pneumococcal immunization unless it is medically contraindicated, or the resident has already been immunized…” The facility’s Communicable Diseases Exposure Control policy (undated) showed, “A facility shall document in the resident’s medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the resident was immunized against hepatitis B.” (C) 10 of 19 Section 300.1210 General Requirements for Nursing and Personal Care 300.1210d)2) d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician.	S9999		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S9999	Continued from page 12 This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to perform blood pressure checks daily as ordered for 1 of 17 residents (R4) reviewed for physician's orders in the sample of 17. The findings include: R4's Physician's Order Sheet printed on 12/15/25 shows an order dated 12/10/25 for: Monitor blood pressure daily x 14 days. R4's Weights and Vitals Summary printed on 12/15/25 shows that he had his blood pressure done on 12/11/25 and no other readings were documented. R4's Medication Administration Record does not document any blood pressure readings for 12/12/25, 12/13/25 or 12/14/25. On 12/16/25 at 12:30 PM, V5 (Licensed Practical Nurse) said that she was not aware that R4 had an order for blood pressure to be done daily. V5 said that his blood pressure had not been done daily as ordered. V5 said that all physician's orders should always be followed but she did not know about the order. On 12/16/25 at 2:00 PM, V1 (Administrator) said that they do not have a policy related to following general physician's orders. (B) 11 of 19 300.1210d)5) Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. This REQUIREMENT was not met as evidenced by:	S9999		

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 12/16/2025

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S9999	Continued from page 13 Based on observation, interview and record review the facility failed to assess residents' wounds upon admission to the facility and as per physician order. The facility failed to perform wound care treatments as ordered by a physician. These failures apply to 2 of 2 residents (R2, R4) reviewed for resident wounds/skin breakdown in the sample of 17. The findings include: 1.R2's admission record showed R2 was admitted to the facility from a local hospital on 12/5/25. R2's hospital records dated 12/3/25 showed R2 was hospitalized and treated for fluid overload related to congestive heart failure, pneumonia, and cellulitis to his bilateral lower legs due to wounds caused by his lymphedema. A wound care physician order for R2 dated 12/8/25 showed, "Once weekly, wash bilateral lower extremities with soap and water. Apply antifungal ointment. Then layer 2 compression wraps." R2's December 2025 physician orders report showed an order, dated 12/5/25, for staff to check R2's skin "daily due to wounds to bilateral lower extremities." The report did not show R2's wound care physician order dated 12/8/25. A wound care physician order for R2 dated 12/8/25 showed, "Once weekly, wash bilateral lower extremities with soap and water. Apply antifungal ointment. Then layer 2 compression wraps." R2's progress notes and treatment administration records (TAR) dated 12/5/25-12/15/25 were reviewed and showed no skin assessments of R2's lower legs had been completed in the facility. The notes and TAR showed no wound care treatments had been provided to R2's lower legs in the facility during that time. On 12/15/25 at 2:58 PM, R2 was seated in a recliner in his room with compression wraps in place to his bilateral lower legs. When he was asked when the last time was, he had his legs unwrapped and wound care treatment provided, R2 stated, "Over a week ago." On 12/16/25 at 10:10 AM, V2 Director of Nursing (DON) stated skin assessments are completed on residents upon admission to the facility and then as per physician order, either daily or weekly. V2 DON stated no skin assessments of R2's bilateral lower legs had been completed in the facility. V2 stated R2's 12/8/25 wound	S9999		

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S9999	Continued from page 14 care physician order “got missed”. The order was never added to R2’s active facility orders so no wound care treatments had been completed in the facility on R2’s legs. The facility’s Skin Assessment policy (undated) showed, “A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter…” The facility’s Wound Treatment Management policy (undated) showed, “Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change.” 2. On 12/15/25 at 2:38 PM, R4 had a dressing to his posterior left lower thigh. R4’s dressing was removed and there was an open wound present. On 12/15/25 at 2:46 PM, V2 (Director of Nursing) said that wound assessments are done weekly by the wound physician. V2 said that wound assessments are important to ensure that the wound is healing and not deteriorating and needing a different treatment intervention. V2 said that the wound physician last came to the facility at the end of November. V2 said that no one has been doing wound assessments since then. R4’s Wound Evaluation and Management Summary dated 11/25/25 shows that he had a stage 2 pressure wound of the left, posterior, lower thigh measuring 6.5 centimeters (cm) x 4.5 cm x 0.1 cm with moderate serous exudate. On 12/16/25 at 9:45 AM, V2 (Director of Nursing) said that there are no additional pressure wound assessments for R4’s wound documented after 11/25/25. The facility’s Pressure Injury Prevention and Management Policy shows, “The RN Unit Manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document as summary of findings in the medical record. The attending physician will be notified of:….The progression towards healing, or lack of healing, of any pressure injuries weekly…” (B) 12 of 19 300.1610a)1)	S9999		

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S9999	Continued from page 15 Section 300.1610 Medication Policies and Procedures a) Development of Medication Policies 1) Every facility shall adopt written policies and procedures for properly and promptly obtaining, dispensing, administering, returning, and disposing of drugs and medications. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. These policies and procedures shall be in compliance with all applicable federal, State and local laws. This REQUIREMENT was not met as evidenced by: Based on observation, interview, and record review the facility failed to obtain and administer a resident's narcotic pain medication as per physician order for 1 of 6 residents (R1) observed in the medication pass. The findings include: R1's current care plan showed R1 was at "risk for pain related to Parkinson's, GERD (gastrointestinal reflux) and arthritis. He has scheduled and PRN (as needed) pain medication to help relieve his pain…" R1's physician order dated 12/10/25 showed R1 was prescribed Hydrocodone/APAP (narcotic pain medication) 7.5/325 mg (milligram) tablets, take one tablet by mouth, four times a day for pain. A facility pharmacy report printed 12/15/25 showed R1 had been prescribed Hydrocodone/APAP since 10/16/25. On 12/15/25 at 11:50 AM, V5 Licensed Practical Nurse (LPN) prepared medications to administer to R1. V5 stated she could not administer R1's scheduled Hydrocodone/APAP to him because the facility was out of this medication for R1. V5 stated, "(R1's) been out of his Hydrocodone for a bit. We don't have a new physician order for it. We can't even take a dose out of our Pyxis machine (automated medication dispensing machine) because we don't have a new order for the medication (Hydrocodone)." V5 stated they have tried contacting R1's physician to reorder R1's Hydrocodone/APAP but the facility's pharmacy has yet to receive an order for the medication from R1's physician. On 12/15/25 at 12:00 PM, V14 Pharmacy Technician stated, "We don't have a new order for (R1's) Hydrocodone. Our pharmacy delivered 12 tablets of	S9999		

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S9999	Continued from page 16 Hydrocodone to the facility for (R1) on 12/11/25. (R1) should have received 4 tablets of the medication on 12/11, 12/12, and 12/13/25 which means he has been out of this medication since 12/14/25. We can't send the medication to the facility without a new physician order." V14 stated no doses of Hydrocodone had been taken out of the facility's Pyxis machine from 12/14/25 and 12/15/25 for R1. V14 stated, "Staff doesn't have access to Hydrocodone in their Pyxis without an active physician order." On 12/16/25 at 10:10 AM, V2 Director of Nursing (DON) stated facility nurses are to order medications from the pharmacy before residents run out of the medications to ensure medications are available for administration in the facility. (B) 13 of 19 300.1630b) Section 300.1630 Administration of Medication b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available, a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review the facility failed to ensure medications were administered per physician orders and standard of practice. This applies to 1 of 6 residents (R4) reviewed for medication administration in the sample of 17. The findings include: On 12/16/25 at 8:32 AM, V5 Licensed Practical Nurse (LPN) was administering R4's morning medications. She administered atorvastatin (cholesterol), amiodarone (cardiac), buspirone (anti-depression), Lasix (water pill), gabapentin (nerve pain), isosorbide ER (extended release) (blood pressure), metformin (diabetes), Entresto (cardiac), spironolactone (water pill), omeprazole (heart burn), Flomax (urinary/prostate),	S9999		

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S9999	Continued from page 17 thiamine (vitamin B1), Toprol XL ER (extended release) (blood pressure), and topiramate (headaches/migraines). V5 LPN verified there was 14 pills in the cup to administer to R4. She crushed all the tablets and opened the capsules pouring the powder into the crushed tablets. Toprol XL ER and Isosorbide ER should not have been crushed per standard of practice. She also omitted a daily vitamin, liquid protein and albuterol nebulizer for a total of 18 medications. R17's medication administration record for the month of December 2025 shows the following medications to be administered at 8:00 AM: amiodarone HCL oral tablet, atorvastatin calcium tablet, daily vit oral tablet, Flomax oral capsule, gabapentin oral capsule, isosorbide mononitrate ER tablet extended release 24 hour, Lasix tablet, liquid protein, omeprazole capsule, spironolactone tablet, thiamine tablet, Toprol XL tablet extended release, albuterol sulfate inhalation nebulization solution, Entresto tablet, metformin HCL tablet, topiramate tablet and buspirone HCL tablet. All of the medications at 8:00 AM were signed off as administered. Daily vit tablet, albuterol and liquid protein were not administered at the time V5 LPN signed off the medications saying they were given. On 12/16/25 at 11:54 AM, V5 LPN stated, "Oh, I didn't give them (daily vit or liquid protein). I can give them now." She was not aware R4 had an albuterol nebulizer scheduled. She looked through the medication cart and could not even find any albuterol nebulizer solution to give R4. She was not aware that extended-release tablets cannot be crushed. The facility's medication administration policy (no date) shows, "Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards or practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: 10. 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, f. Right documentation. 11. Review MAR to identify medication to be administered. 17. Administer medication as ordered in accordance with manufacturer specifications…. C. Crush medications as ordered. Do not crush medications with "do not crush" instructions…." (B) 14 of 19 300.2210b)1)	S9999		

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S9999	Continued from page 18 Section 300.2210 Maintenance b) Each facility shall: 1) Maintain the building in good repair, safe and free of the following: cracks in floors, walls, or ceilings; peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering, such as tile or linoleum; loose handrails or railings; loose or broken window panes; and any other similar hazards. This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review the facility failed to ensure resident rooms and common areas were maintained in good repair. This applies to all 36 residents who reside at the facility. The findings include: The Resident Roster dated 12/15/25 shows that there are 36 residents residing in the facility. The facility has a North Unit and South Unit. The North Unit is the only unit currently being utilized for residents. On 12/16/25 at 9:11 AM during tour of the North Unit the following was observed: A. Peeling/chipped paint and scratches on the wall in room 107, 121 and 124 B . Peeling paint on the ceiling in the shower room and common bathroom C. Eleven chipped floor tiles in front of the shower room door and chipped floor tiles in front of the TV Lounge door D. Broken plastic light cover in room 124 E. Multiple resident rooms, resident bathrooms and utility rooms had scratched/chipped paint on the doors and door frames that extended more than halfway up the doors/door frames F. The dining room had multiple areas of chipped paint G. The common bathroom had a bathtub that was leaking from the faucet and had rust stains on it (V13, Maintenance) says that it does not work), a tile	S9999		

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S9999	Continued from page 19 missing from the wall and the toilet was not bolted to the floor and was unsteady H. The exit door in the dining room had missing pieces of weather stripping or loose pieces of weather stripping I. Multiple resident rooms, the shower room, common areas and hallways had loose, cracked, chipped or missing baseboards. On 12/15/25 at 1:43 PM, there was a large bath towel on the floor in front of the closed shower room door. The towel was wet. Inside the shower room was another bath towel on the floor of the shower room and it was saturated with water. V11 (CNA) said that the shower room leaks when a resident is taking a shower. V11 said that water leaks out from under the door and leaks through the wall and into the common area that has resident chairs. On 12/16/25 at 9:11 AM, V13 (Maintenance Director) said that he has worked at the facility for more than 4 years and some of the doors and door frames have never been touched/painted by him. V13 said that they did start painting in the past but then someone decided that they did not like the color so they stopped and he did not hear anything after that. On 12/16/25 at 10:26 AM, R14 said that the chipped paint on the walls and doors does not look good. At 10:45 AM, R5 said that the doors look bad and if they would give her some paint, she would paint it herself. R5 pointed at a baseboard that was off in her room and said that that does not look good either but it is probably from a wheelchair hitting it but she does not use a wheelchair and it would be nice to be fixed. The facility's Safe and Homelike Environment Policy shows, "In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment…..Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas….Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment." (C) 15 of 19 300.2210b)1)	S9999		

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S9999	Continued from page 20 Section 300.3060 Nursing Unit e) Bath and Toilet Rooms 1) The maximum capacity of resident beds on each floor shall be used to determine the number of fixtures required even though some of the beds may not be occupied. C) Provide a minimum of one bathtub or shower for each 15 resident beds on each floor. This REQUIRMENT was not met as evidenced by: Based on observation, interview and record review the facility failed to have the required amount of working showers or bathtubs per resident beds. This applies to all 36 residents who reside at the facility. The findings include: The Resident Roster dated 12/15/25 shows that there are 36 residents residing in the facility. The facility has a North Unit and South Unit. The North Unit is the only unit currently being utilized for residents. The North Unit had one shower room functioning and the room had one shower head in it. On 12/16/25 at 1:07 PM, V13 (Maintenance Director) said that they currently have only one shower that all the residents utilize. V13 said that the bathtub is not currently functioning and there are no other functioning showers for resident use in the facility. (C) 16 of 19 300.2210b)1) Section 300.3100 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required. (B) This REQUIREMENT was not met as evidenced by:	S9999		

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S9999	Continued from page 21 Based on observation and interview the facility failed to ensure all exterior doors had a functioning alarm system in place when they were opened. This has the potential to affect all 36 residents who reside at the facility. The findings include: The Resident Roster dated 12/15/25 shows that there are 36 residents residing in the facility. On 12/16/25 at 9:11 AM during an environmental tour of the facility, the dining room exterior exit door had a sliding bolt latch lock installed on it and a door alarm sensor installed on it. The lock was unlocked by this surveyor and the door was opened. No alarm sounded when the door was opened. On 12/16/25 at 9:40 AM, V13 (Maintenance Director) said that the dining room door should have alarmed when it was opened. V13 said that the battery must have died. On 12/16/25 at 2:00 PM, V1 (Administrator) said that the facility does not have a policy on exit door alarms. (C) 17 of 19 300.3120h)1)A) Section 300.3120 Mechanical Systems h) Heating, Ventilating, and Air Conditioning Systems 1) Areas of a nursing home used by residents of the nursing home shall be air conditioned and heated by means of operable air-conditioning and heating equipment. The areas subject to this air-conditioning and heating requirement include, without limitation, bedrooms or common areas such as sitting rooms, activity rooms, living rooms, community rooms, and dining rooms. (Section 3-202(8) of the Act) A) The mechanical system shall be capable of maintaining a temperature of at least 75 degrees Fahrenheit, pursuant to the requirements of Section 300.670(j). This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review the facility failed to ensure common areas and the shower room were at a comfortable temperature. This applies to	S9999		

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S9999	Continued from page 22 all 36 residents residing in the facility. The findings include: The Resident Roster dated 12/15/25 shows that there are 36 residents residing in the facility. On 12/15/25 during the noon meal, R9 was sitting in the dining room for lunch. R9 had a sweatshirt on and a blanket over her shoulders. R9 stated, “It’s cold in here.” R10 was sitting at the dining room table with a sweatshirt on and stated, “I am freezing.” R11, R12 and R13 were all in the dining room and had sweatshirts on. R11-R13 all said that the dining room is cold. R11 said that it is especially cold in the mornings. On 12/15/25 at 12:45 PM, the air temperature of the dining room was between 70 and 71 degrees Fahrenheit. V13 (Maintenance Director) said that he likes to keep it around 70-71 degrees but may turn it up to 72 degrees if it is really cold outside. On 12/16/25 at 9:11 AM, during tour of the facility with V13, the activity room was 67 degrees Fahrenheit. There were residents in the activity room that had sweatshirts and blankets on. The shower room air temperatures were between 59 and 65 degrees Fahrenheit. R14 and R16 both said that the shower room is always very cold. On 12/16/25 at 10:15 AM, V11 (Certified Nursing Assistant) said that the shower room is always cold and they do get resident complaints about it. V11 said that there is no heat in the shower room. The facility’s Safe and Homelike Environment Policy shows, “The facility will maintain comfortable and safe temperature levels. The facility should strive to keep the temperature in common resident areas between 71 and 81 degrees Fahrenheit….” (C) 18 of 19 300.3210t) Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual, or psychological abuse, neglect, exploitation, or misappropriation of property. This REQUIREMENT was not met as evidenced by:	S9999		

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S9999	Continued from page 23 Based on observation, interview and record review the facility failed to keep residents free from physical abuse. This applies to 2 of 17 residents (R5 and R8) reviewed for abuse in the sample of 17. The findings include: On 12/15/25 throughout the survey, R8 was up, wandering around the facility. She would pick up random things and carry them around in her hands. R8's face sheet lists her diagnoses to include: dementia, bipolar disorder, generalized anxiety disorder, obsessive-compulsive disorder, schizophrenia and Alzheimer's disease. R8's progress notes dated 9/2/25 shows, "Administrator (V1) brought to this nurse's attention on 8/31/25 during dinner time that this resident had a resident altercation with another resident." R8's progress notes dated 10/18/25 shows, "At 1556 (3:56 PM) resident was removed from peers' room after striking her on the hand…. While nurse was assessing 1st peer, R8 struck another peer on the hand while in the hallway. That incident was witnessed by activity aide and CNA (certified nursing assistant) who both separated and ensured resident's safety before notifying this nurse…." R8's progress notes dated 10/19/25 shows, "Resident is alert with confusion at all times per usual. Up wandering throughout common areas between meals. Requires frequent supervision and redirection as she enters peers rooms, the nurses station, and the dining room and takes items, food, drink that don't belong to her. Resident does not respond well to intervention, typically becoming agitated and occasionally using her arms and body to physically move staff when they are blocking her entry into peers rooms or blocking her from picking up items and food that do not belong to her. Because her cognition is so severely impaired, resident is usually unable to understand situation and the actions of others comprehends and responds inappropriately/inaccurately to verbal communication. She also has difficulty communicating her own needs verbally…." R8's progress notes dated 10/26/25 shows, "At around 1830 (6:30 PM) writer was made aware from the assigned CNA that the resident hit another resident on his left upper chest. The incident was witnessed by the assigned CNA while the CNA was walking down Long-Hall to redirected R8 back to her room. The peer was trying to	S9999		

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 12/16/2025

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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S9999	Continued from page 24 enter his room after having his dinner when the resident started rubbing on the peers chest and then took the peers book from the room which was on the bed 123-1 bed one. The peer was trying to gently take the book back from the resident, which caused the resident to hit the peer on the left upper chest....” The facility’s long-term care facility & IID- serious injury incident and communicable disease report dated 9/2/25 shows, “On September 2, 2025 at approximately 12:30pm, Administrator was made aware from staff member that R5 reported that on 8/31/25 during dinner time. R8 had a clothing protector and R5 attempted to remove the clothing protector form R8 when the clothing protector came free and accidently bumped R5 in the face, another resident introjected yelling at R8 to leave R5 alone with R8 struck the other resident in the shoulder….” On 12/16/25 at 12:35 PM, R5 stated, she was involved in an incident a couple of months ago with R8. She was in the dining room for dinner when R8 came up to her and tried to grab her bib. She tried to take it away from her but R8 grabbed and pulled so hard that she got the bib. She then hit her in the face with the bib. Another resident (who is no longer residing in the facility) was sitting next to her and told R8 to stop. R8 then started hitting her on the shoulder multiple times. She likes to take stuff and if you try to take it back, she will hit you. We have been advised not to interfere. She also stated, when she sees R8 coming up behind her it makes her “nervous”. On 12/16/25 at 12:44 PM, V5 LPN stated, R8 has hit several residents. It has been going on for a while. She has dementia. It is a continuous challenge. On 12/16/25 at 1:02 PM, V1 Administrator stated, she doesn’t consider it abuse because R8 is touching them but not “hitting” them. R8’s current care plan shows, “Focus: R8 has history of being physically aggressive r/t (related to) dementia. 10/18/25 resident wandering and rearranging another resident’s room and activity room, taps others on the shoulder/hand while attempting to communicate.” R8’s current care plan shows, “Focus: Resident is known/has history of displaying inappropriate behavior and/or resisting care/services, such as showers and changing her clothes. Specific behavior exhibited likes to touch, hug, or kiss others. She is noted to be pacing up and down the halls….” The facility’s abuse, neglect and exploitation policy	S9999		

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S9999	Continued from page 25 dated 10/1/25 shows, “Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation or resident property. Definitions: “Abuse” means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations….” (B) 19 of 19 300.3240c) Section 300.3240 Abuse and Neglect c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative and to the Department. (Section 3-610(a) of the Act) This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to report and investigate incidents of alleged physical abuse to the Illinois Department of Public Health (IDPH). This applies to 1 of 6 residents (R8) reviewed for abuse in the sample of 17. The findings include: R8’s progress notes dated 10/18/25 & 10/26/25 show, 2 separate incidents where R8 allegedly “hit” another resident. On 12/16/25 at 8:16 AM, V1 Administrator stated, she couldn’t find the soft files for R8’s incidents on 10/18/25 & 10/26/25. At 1:02 PM, V1 Administrator stated, she didn’t feel either incident was abuse so she never reported it to the department (IDPH). The facility’s abuse, neglect and exploitation policy dated 10/1/25 shows, “Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation or resident property. Definitions: “Abuse” means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish,	S9999		

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S9999	Continued from page 26 which can include staff to resident abuse and certain resident to resident altercations…. VII. Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and no not result in serious bodily injury….” (C)	S9999		