

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0058834		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/20/2026	
NAME OF PROVIDER OR SUPPLIER LA BELLA OF DANVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 1701 NORTH BOWMAN , DANVILLE, Illinois, 61832			
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S0000	Initial Comments Complaint Investigations: 2661387/ 2732845, 2661425/ 2735392, 2661578/ 2736275		S0000				
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1220b)3) 300.3210t) 300.3240e) 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. 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		S9999				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 provided to each resident to meet the total nursing and personal care needs of the resident. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. 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. Section 300.3240 Abuse and Neglect e) When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to protect residents' right to be free from sexual abuse and assault perpetrated by another resident (R5) with known sexual behaviors: and failed			S9999			

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S9999	Continued from page 2 to separate a resident (R5) from contact with other residents after an allegation of sexual abuse to prevent further sexual abuse and assault. These failures affect two residents (R4 and R6) on the sample list of fourteen. Findings include: R4's Census Detail and Medical Diagnoses List, both dated 2/10/26, document R4 was admitted to the facility on 1/26/24 with diagnoses including Alzheimer's disease, transient ischemic attacks (mini strokes), altered mental status, muscle weakness, difficulty walking, and need for assistance with personal care. On 2/6/26 at 10:33 AM, R4 was seated in a wheelchair in the hallway next to the nurses' station. R4 could not formulate a response relevant to questions being asked. R4 continuously pointed her right index finger in different directions and spoke in a mumbling manner, occasionally uttering sensible words about "brother" or "cooking." R4's Care Plan dated 1/9/26 documents R4 is at risk of abuse. A prior Care Plan dated 4/3/24 documented R4 was at low risk of abuse and was revised on 5/8/25 to reflect R4 was the alleged victim of abuse from another resident on 5/7/24. The facility's Serious Injury Initial Report dated 5/7/25 documents an allegation R5 had touched the breasts of R4. The facility's Center for Medicare and Medicaid Services Form 2567 (Statement of Deficiencies) and associated Resident Numerical Reference dated 4/17/24 document a cited incident involving R5 (then R205) as the perpetrator of sexual abuse toward R4 (then R206), in which R5 touched R4's breasts. R6's Census Detail and Medical Diagnoses List, both dated 2/10/26, document R6 was admitted to the facility on 3/22/25 with diagnoses including dementia, depression, pseudobulbar affect, reduced mobility, anxiety, lack of coordination, and bipolar disorder. The same list documents an additional diagnosis of confirmed adult sexual abuse dated 2/4/26. On 2/6/26 at 10:55 AM, R6 was seated in a wheelchair in her room. R6 made no verbal responses to questions and only produced intermittent humming noises. R6 wheeled herself through her room, into the hallway, and back into her room without any apparent direction or intended destination.		S9999				

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S9999	Continued from page 3 R6's Care Plan dated 2/5/26 documents R6 experienced sexual assault by another resident, placing her at risk for emotional distress, physical harm, and a compromised sense of safety. A prior Care Plan dated 6/2/25 documents R6 is at risk of abuse. R5's Census Detail and Medical Diagnoses List, both dated 2/10/26, document R5 was originally admitted to the facility on 8/11/14 with diagnoses including cerebral infarction, anxiety, mood disorder, high-risk heterosexual behavior (7/30/24), schizoaffective disorder bipolar type, and moderate vascular dementia with agitation. R5's Care Plan initiated 1/6/25 documents R5 wanders aimlessly throughout the facility. The same Care Plan documents R5 inappropriately touches other residents and staff and makes inappropriate comments. A Care Plan dated 1/6/25 further documents R5 is an identified offender with a criminal history including domestic battery (2003), battery and resisting a peace officer (1986), contempt of court (1983), and thefts and burglaries (1983, 1995, and 2006). On 2/6/26 at 10:24 AM, V11 (Housekeeper) stated on 2/2/26 she noticed two wheelchairs in R6's room. Knowing R6 resided alone, she entered to determine why there was a second wheelchair present. V11 stated R6 was lying on the bed and R5 had his hand in R6's "diaper area." V11 clarified R6 was not wearing her diaper. V11 reported she informed Certified Nursing Assistant V13 and Nurse V12 about what she saw. On 2/6/26 at 10:40 AM, R5 was seated in a wheelchair in the main dining room engaged in an occupational therapy activity. R5 had a small quart-sized bucket of clothespins colored green, red, blue, and yellow, along with a stack of colored and numbered cards. R5 drew a card from the deck (observed as a green 6), selected and counted six green clothespins, and clipped them to the card—three with his right hand and three with his left. He received no instructions while performing the activity. A stack of completed cards was in front of him, with a yellow number one card on top holding one yellow clothespin. During the observation, R5 stated he did not have any girlfriends at the facility because every time he picked one, she would pick another man. R5 stated there were a few women he would like to talk to, but they did not want to talk to him. R5 stated he had touched one woman "down below," then clarified "on her pu*s" (vagina) and stated it occurred "in her room." R5 added		S9999				

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S9999	Continued from page 4 he thought the woman wanted him to touch her but "couldn't prove it." On 2/6/26 at 1:10 PM, V12 (Licensed Practical Nurse) stated she had been the nurse on duty on 2/2/26 when V11 reported seeing R5 touching R6 in her "diaper area." V12 stated she responded to R6's room to remove R5 and observed R6's bed sheet pulled to the side, R6's incontinent undergarment unfastened, and R5's finger inside R6's vagina. On 2/6/26 at 1:50 PM, V3 (Assistant Director of Nursing) confirmed the incident involving R5 touching R6 occurred on 2/2/26. V3 stated R6 went to the emergency room for evaluation on 2/3/26 because initial reports indicated R5 had been touching R6 in her diaper and thigh area, which was why the Nurse Practitioner (V9) initially conducted only a brief visual examination. V3 further stated after administrative investigation began, witnessing staff reported actual vaginal touching and penetration had occurred. On 2/6/26 at 3:22 PM, V13 (Certified Nursing Assistant) stated a family member (V21) of another resident (R11) informed her that R5 had grabbed R4 in her private area in the dining room. V13 stated that at the time of the report she had just returned inside after supervising residents who were smoking outside. V13 stated she directed R5 to go down the hall to his room and then went to remove her coat. She stated that while she was hanging up her coat, R5 proceeded down the hall to R6's room, where the second sexual incident occurred. V13 stated when she returned to the dining room after removing her coat, she received a report from V11 (Housekeeper) that R5 was touching R6 in her "diaper area." V13 stated that when she arrived at R6's room after V11's report, V12 (Licensed Practical Nurse) was already removing R5 from R6's room. V13 further stated R6's bed sheet was pulled to the side, R6's incontinent undergarment was unfastened exposing her genital area, and R6 was tearful. On 2/11/26 at 8:55 AM, V21 (family member of R11) stated she witnessed R5 "poking his finger into the private area" of R4. V21 stated she moved R5's wheelchair to prevent further contact and informed Certified Nursing Assistant V13 when she arrived. V21 stated both residents were in wheelchairs, so the action could not have been accidental, and she believed R5's actions were intentional. On 2/11/26 at 3:24 PM, V2 (Director of Nursing) stated neither R4 nor R6 had the cognitive capacity to consent to sexual activity.	S9999					

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S9999	Continued from page 5 On 2/11/26 at 4:20 PM, V1 (Administrator) confirmed neither R4 nor R6 had the cognitive capacity to consent. The facility's Investigative Report (partially completed) dated 2/3/26 documents an initial interview with V12 conducted by V1 and V2, during which V12 reported receiving V11's report R5 had his hand in R6's diaper area. V1 documented V12 appeared uncomfortable being interviewed by two males and noted V3 would conduct a follow-up interview. During interview, V12 demonstrated what she saw and stated when she entered R6's room, R5 had his finger inside R6's vagina. R5's Nursing Progress Note dated 2/2/26 documents R5 was evaluated by Nurse Practitioner V9 at 11:18 AM due to sexually inappropriate touching of another resident. A note dated 2/3/26 documents R5 was placed on one-to-one supervision at 11:59 AM. R6's Nursing Progress Note dated 2/2/26 at 11:38 AM documents she was evaluated by Nurse Practitioner V9 after being touched sexually in an inappropriate manner. The facility policy Identifying Types of Abuse dated September 2022 defines sexual abuse as any nonconsensual sexual contact of any kind with a resident, including unwanted touching, especially of the breasts or perineal area, and all types of sexual assault. The facility policy Abuse, Neglect, and Exploitation dated 10/1/25 documents the facility will implement policies to prevent all types of abuse. The facility policy Abuse, Neglect and Exploitation dated 10/1/25 documents that the facility will implement policies to prevent all types of abuse and will make efforts to ensure residents are protected from psychosocial harm and additional abuse, including room and staffing changes to protect residents from an alleged perpetrator. The policy states staff must respond immediately to protect alleged victims. The facility's staff in-service training for Abuse Prevention and Reporting dated 8/29/25 documents, by signature, that V11, V12, and V13 received abuse prevention training. On 2/11/26 at 4:24 PM, V1 (Administrator) stated he expects staff to take steps to prevent further abuse. V1 stated staff should immediately remove the resident from the incident and not call him until the situation is under control. V1 stated it is part of facility		S9999				

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S9999	Continued from page 6 policy for staff to remove the perpetrator from the incident. V1 stated he needed to have a conversation with V13 that would include education that removing her coat in that type of situation is not a priority. V1 stated V13 could have taken multiple actions to prevent further abuse but described this as "Monday morning quarterbacking," and stated he would discuss what she could do differently in the future, such as moving the perpetrator to the far side of a table and asking other staff to monitor while she reported the incident. (A)			S9999			