STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146084	A. Building B. Wing	09/16/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a discharge planning process and include this process in the resident's electronic medical record including the comprehensive plan of care for 2 of 3 residents (R2, R3) reviewed for discharge planning in the sample of 5.The findings include:1. On 9/16/25 R2 stated he was ready to go home and has been for a while. R2 stated he was supposed to be discharged on Monday, that did not happen. R2 stated now someone stated it would probably be on Thursday. R2 stated he was told that they were waiting for the doctor's signature before he can leave. R2 stated he did not know anything about his discharge plans other than he is going to be discharged . On 9/16/25 at 12:11 PM, V9 Social Services stated R2 was finished with therapy and waiting for the doctor's order for discharge. V9 stated the facility just had a new medical director start and they are waiting on the order from him. V9 stated the current plan is for R2 to discharge home on Thursday (9/18/25) with his wife. On 9/16/25 at 1:30 PM, V3 Licensed Practical Nurse (LPN) stated in the Minimum Data Set (MDS) for a resident it will show if the resident plans to discharge from the facility. V3 reviewed R2's current care plan and stated she did not see a plan for R2's discharge. V3 stated the way the nurse will know about a resident's discharge is through communication on the electronic medical records home page. V3 stated she does not become involved in the resident's discharge until the day of discharge. V3 stated she doesn't see a lot of discharge information for residents. V3 stated it is important to know what the resident will need and that safety measures are in place.On 9/16/25 at 1:40 PM, V4 LPN stated discharges are communicated by dashboard alerts in the electronic medical record. V4 stated a resident should have a care plan in place regarding discharge; it is a regulatory requirement. V4 reviewed R2's medical record and stated she did not see any discharge plans in place and R2 is being discharged . V4 stated social services should initiate the process and the MDS/Care Plan Coordinator should do the care plan.On 9/16/25 at 1:51 PM V5 MDS/Care Plan Coordinator stated they start talking about a resident's discharge when they first come into the building. V5 stated it is discussed at the first care plan meeting. V5 stated if the resident is a rehab to home resident, then she has a form that she fills out. The information from the form is used to fill out an assessment in the electronic medical record. V5 stated she writes it on paper and then fills it in later. V5 stated R2 did not have an assessment or discharge plan in the electronic medical record. The Interim Care Plan assessment dated [DATE] for R2 showed a discharge plan was initiated and R2 would need assistance with some activities of daily living. The Minimum Data Set, dated [DATE] for R2 showed under section Q the resident's overall goal was to return to the community. Under the section for discharge plan it was marked that an active discharge plan was occurring for the resident to return to the community. R2's Comprehensive Care Plan dated 8/4/25 showed under the Social Service section the name that he prefers to be called and his code status; there was no discharge plan in place. The rest of R2's care plan did not show any current and/or future plan for discharge.On 9/16/25 at 2:35 PM, V1 Administrator and V2 Director of Nursing stated residents should have a discharge plan in place. They stated the facility did not have a medical record for three weeks. R2 is waiting for an order so he can go home. The Physician Orders for September 2025 for R2 did not show any orders for discharge.The Face Sheet dated 9/16/25 for R2 showed diagnoses including chronic obstructive pulmonary disease, heart failure, type 2 diabetes mellitus, hypothyroidism, hypertension, hyperlipidemia, aortic stenosis, benign prostatic hypertrophy, and atherosclerotic heart disease. The facility's Transfer and Discharge policy (11/2024) showed the comprehensive, person-centered care plan shall contain the resident's goals for admission and desired outcomes shall be in alignment with discharge. Supporting documentation shall include evidence of the residents or residents representative's verbal or written notice of intent to leave the facility, a discharge plan, and documented discussions with the resident and/or resident representative. 2. On 9/16/25 R3 stated she did not know how long she would be at the facility. R3 stated she has an injured right shoulder and has cancer that she is going to be receiving treatments. R3 stated she didn't know what her plan was; just that she was going to be treated for cancer.The MDS dated [DATE] for R3 showed under section Q that her overall goal was to be discharged to the community.The Care Plan dated 8/29/25 for R3 did not show any information and or plan related to discharge.The Face Sheet dated 9/16/25 for R3 showed diagnoses including emphysema, tobacco use, lung cancer, chronic gastric cancer, personal history of pulmonary embolism, anxiety disorder, ocular myiasis, and aural myiasis.On 9/16/25 at 2:35 PM, V1 Administrator and V2 Director of Nursing stated residents should have a discharge plan in place.The facility's