

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2026
NAME OF PROVIDER OR SUPPLIER LA Bella of Morrison		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure an initial assessment was completed of wounds upon admission and failed to ensure weekly wound assessments were completed for 2 of 3 residents (R3, R1) reviewed for wounds in the sample of 7. The findings include: 1. R3's face sheet showed he was admitted to the facility 3/12/26 with diagnoses to include chronic obstructive pulmonary disease, severe calorie malnutrition, gangrene, chronic respiratory failure, and retention of urine. R3's record showed he was admitted on hospice services. R3's facility assessment dated [DATE] showed he has moderate cognitive impairment and requires extensive assistance for all cares. On 4/14/26 the facility provided wound assessments for R3's skin conditions including a 3/12/26 Skin check which showed, . Foot evaluation completed. Skin Issues: . Location Right heel. This assessment showed no measurements and did not include R3's wound to his left foot. The only other assessment found in R3's record was dated 4/10/26 and showed, . Wound 1. Left foot. Size: 27 cm x 11 cm x 1 cm, Wound Base: 100% eschar. Wound 2. Right foot. Size: 27 cm x 12 cm x 0.1 cm, Wound Base: 100% eschar. Assessment/Plan: Continue recommended treatment 4/10/26. Patient has frostbite to bilateral feet. The patient is currently under hospice services. Goals of care remain to minimize pain and risk of infection. Continue palliative wound management. Patient is very high risk for ongoing wound decline and development of new wounds. The patient's current wounds are considered unavoidable. It is anticipated that as the patient continues to progress toward end of life that they will continue to experience wound decline. No wound assessments were documented for R3's right and left lower extremity wounds upon admission 3/12/26 and no weekly assessments were documented the week of 3/19, 3/26, or 4/2. On 4/14/26 at 1:28 PM, V2 DON (Director of Nursing) said, Since I started here March 17th we have a contract with [a wound care company] . the floor nurses were doing the weekly assessments but now since [the wound care company] started, they are doing the weekly measurements of the wounds. On 4/14/26 at 2:05 PM, V1 (Administrator) said, The former DON was the one who was responsible for doing the wound measurements and the oversight of the assessments in the [Electronic Health Record]. We identified some concerns with her, and she has since been terminated from her position. We hired [V2] as our new Director of Nursing and brought on a wound care company. The wound company has rounded twice now since their contract started. They saw [R1] and [R2]. The problem we identified with the previous DON doing the weekly assessments looked like the first of March through the third week of March. 2. R1's face sheet showed he was admitted to the facility 1/15/26 with diagnoses to include chronic congestive heart failure, insomnia, acquired absence of right leg below knee, acquired absence of right foot, acquired absence of left foot, cardiac pacemaker, and severe protein-calorie malnutrition. R1's 3/9/26 facility assessment showed he has no cognitive impairment. R1's care plan initiated 2/5/26 showed, Resident has actual impairment to skin integrity (surgical) to bilateral lower extremities related to amputation of toes and BKA (below knee amputation) . Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. R1's weekly wound assessments showed they were completed to his right and left amputation surgical sites on 2/27/26. The next (continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>wound assessments completed for R1's surgical amputation sites to his right and left lower extremities was completed 3/27/26. No weekly assessments were completed for the right stump wound or the left stump wound on 3/6/26, 3/13/26, 3/20/26, and 4/3/26.R1's complete medical record showed no evidence of R1 refusing wound assessments. On 4/14/26 at12:43 PM, R1 said, They come and measure it now. The wound doctor does it. there was a guy who would come in here every once in a while, to measure them but he only came in a couple times.The facility's policy and procedure implemented 10/1/25 showed, Wound Treatment Management. Policy: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: .Lack of progression towards healing.Changes in the characteristics of the wound . Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights.The facility's policy and procedure implemented 10/1/25 showed, Documentation of Wound Treatments. Policy: The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment. Policy Explanation and Compliance Guidelines: .Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. The following elements are documented as part of a complete wound assessment: .Type of wound (pressure injury, surgical, etc.) and anatomical location. Measurements: height, width, depth, undermining, tunneling. Description of wound characteristics: Color of the wound bed.Type of tissue in the wound bed (i.e., granulation, slough, eschar, epithelium).Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated). Presence, amount, and characteristics of wound drainage/exudate.Presence or absence of odor.Presence or absence of pain.</p>		