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	05/05/2026

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were treated in a dignified manner. This applies to 3 of 13 residents (R4, R6 & R12) reviewed for dignity in the sample of 15. The findings include: On 5/4/26 at 9:03 AM, R6 stated, V10 former agency Certified Nursing Assistant (CNA) just showed up going into rooms asking if we wanted to go to the bar and get drunk. I told him no. I don't care for that goofball. I don't give a shit about him. On 5/4/26 at 9:12 AM, R4 stated, V10 former agency CNA was her CNA. He would give her cares but never say much to her. All of the sudden she found out that he was terminated from the facility and he came in acting like her best friend. He came in her room and tried to hug her. A nurse (V11 Licensed Practical Nurse (LPN)) was in the hallway telling him, he shouldn't be there and to leave. She stated, she was in shock and didn't know what was going on. On 5/4/26 at 11:36 AM, R12 stated, V10 former agency CNA came in his room asking if I wanted to go the bar with him. I told him no, get out of my room. On 5/5/26 at 12:43 PM, V11 LPN stated, she found V10 former agency CNA in R4's room laying on her. R4 was screaming and very upset. He stood up and left the room. I stayed and consoled R4. She was upset and scared because of the things he was saying to her about being terminated. She thought she was going to get blamed for it or involved in it. On 5/6/26 at 12:06 PM, V1 Administrator stated, V10 former agency CNA was DNR'd (do not return) for creating a non-homelike environment. He came back two times after being DNR'd causing a scene and bothering residents. He was asking residents to go to the bar and trying to get them to say bad things about the facility. R4's minimum data set (MDS) dated [DATE] shows, she is cognitively intact. R6's MDS dated [DATE] shows, he is cognitively intact. R12's MDS dated [DATE] shows, he is cognitively intact. The facility's resident rights policy dated 10/1/25 shows, Resident Rights: The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 4. Respect and dignity. The resident has a right to be treated with respect and dignity. 8. Safe environment. The resident has the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident was free from physical abuse for 1 of 4 residents (R4) reviewed for abuse in the sample of 15.The findings include:A health status note dated 2/26/26 showed R1 wandered into another resident's (R4) room and tried to take a box of Kleenex. R1 and R4 held onto the box of Kleenex and tugged back and forth. The note showed, Resident (R1) then hit other resident (R4).R4's resident assessment dated [DATE] showed R4 was cognitively intact.R1's current care plan showed R1 was severely cognitively impaired due to her diagnosis of dementia. The plan showed R1 was ambulatory and wandered throughout the facility. The plan showed, Resident wandering and rearranging another resident's room. Resident likes to touch, hug, or kiss others. Resident has a history of being physically aggressive. On 5/4/26 at 8:46 AM, R4 stated R1 goes into everyone's room and takes things. This happens every day. One time she came in here and tried to take my things. I am helpless and can't get out of bed, so I started yelling at her and yelling for help (from staff). R4 stated R1 told R4 I will show you and then R1 punched R4 in the arm. R4 stated, (R1) was mad. She punched my right arm. It wasn't a slap; it was a punch. On 5/4/26 at 12:10 PM, V8 Licensed Practical Nurse (LPN) stated, On 2/22/26, (R1) wandered into (R4's) room but there was no physical contact. On 2/26/26, (R1) wandered into (R4's) room again. That's when (R1) hit (R4). V8 stated she immediately reported the physical altercation to V1 Administrator as V1 was the facility's abuse coordinator.On 5/4/26 at 11:55 AM, V1 Administrator stated that a resident hitting another resident is a form of physical abuse and is investigated as abuse. V1 stated she did not report or investigate the incident on 2/26/26 between R1 and R4 because she knew nothing about the incident. I was not aware of this incident until today.The facility's Abuse, Neglect, and Exploitation policy dated 10/13/25 showed, 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 of resident property. 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. Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to report an allegation of physical abuse to the facility administrator and other officials, including the State IDPH for 1 of 4 residents (R4) reviewed for abuse in the sample of 15.The findings include:A health status note dated 2/26/26 showed R1 wandered into another resident's (R4) room and tried to take a box of Kleenex. R1 and R4 held onto the box of Kleenex and tugged back and forth. The note showed, Resident (R1) then hit other resident (R4).On 5/4/26 at 8:46 AM, R4 stated R1 goes into everyone's room and takes things. This happens every day. One time she came in here and tried to take my things. I am helpless and can't get out of bed, so I started yelling at her and yelling for help (from staff). R4 stated R1 told R4 I will show you and then R1 punched R4 in the arm. R4 stated, (R1) was mad. She punched my right arm. It wasn't a slap; it was a punch. On 5/4/26 at 12:10 PM, V8 Licensed Practical Nurse (LPN) stated she immediately reported the physical altercation on 2/26/26, between R1 and R4 to V1 Administrator as V1 was the facility's abuse coordinator.On 5/4/26 at 11:55 AM, V1 Administrator stated that a resident hitting another resident is a form of physical abuse and is investigated as abuse. V1 stated staff are to report any facility abuse allegations to her immediately. V1 stated she did not report or investigate the incident on 2/26/26 between R1 and R4 because she knew nothing about the incident. I was not aware of this incident until today. V1 stated V8 LPN never reported the 2/26/27 incident, involving R1 and R4, to V1.The facility's Abuse, Neglect, and Exploitation policy dated 10/13/25 showed, 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 of resident property. Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. 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 the 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 do not result in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review the facility failed to investigate an allegation of physical abuse for 1 of 4 residents (R3) reviewed for abuse in the sample of 15.The findings include:A health status note dated 2/26/26 showed R1 wandered into another resident's (R4) room and tried to take a box of Kleenex. R1 and R4 held onto the box of Kleenex and tugged back and forth. The note showed, Resident (R1) then hit other resident (R4).On 5/4/26 at 8:46 AM, R4 stated R1 goes into everyone's room and takes things. This happens every day. One time she came in here and tried to take my things. I am helpless and can't get out of bed, so I started yelling at her and yelling for help (from staff). R4 stated R1 told R4 I will show you and then R1 punched R4 in the arm. R4 stated, (R1) was mad. She punched my right arm. It wasn't a slap; it was a punch. On 5/4/26 at 12:10 PM, V8 Licensed Practical Nurse (LPN) stated she immediately reported the physical altercation on 2/26/26, between R1 and R4 to V1 Administrator as V1 was the facility's abuse coordinator.On 5/4/26 at 11:55 AM, V1 Administrator stated she did not report or investigate the incident on 2/26/26 between R1 and R4 because she knew nothing about the incident. I was not aware of this incident until today. V1 stated V8 LPN never reported the 2/26/27 incident, involving R1 and R4, to V1.The facility's Abuse, Neglect, and Exploitation policy dated 10/13/25 showed, 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 of resident property. Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. An immediate investigation is warranted when suspicion of abuse neglect or exploitation, or reports of abuse, neglect or exploitation occur. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation; 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and the cause; 6. Providing complete and thorough documentation of the investigation.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure prescribed treatments were done for a resident with a surgical wound. This applies to 1 of 3 residents (R6) reviewed for wound care in the sample of 15. The findings include:R6's face sheet lists his diagnoses to include: absence of left foot, absence of right leg below the knee, severe protein-calorie malnutrition and chronic systolic congestive heart failure. On 5/5/26 at 10:15 AM, V4 Registered Nurse (RN) was changing R6's dressing to his right stump surgical dehiscence. R6 had a small pinpoint open area on the incision where he had a below the knee amputation. She cleaned the wound and was going to apply xeroform (petroleum based gauze) to his wound and cover with a dressing. R6 told her, No that is not the right dressing. She asked, what do you mean? Your orders say xeroform and a dressing. R6 stated, no they changed that order and have been using the white stuff (collagen) and then a dressing. He continued to explain the xeroform was keeping the wound wet and the wound care doctor didn't want that. V4 RN said, ok and she would check the orders. V4 RN and this surveyor went out of the room to the computer to verify the order. The order in the computer for R6 at that time was for xeroform and to cover with a dressing. V4 RN went back to R6 and explained what the order stated. He stated no, that is incorrect. V4 RN told him ok and she would follow up with the wound care doctor. V4 RN stated, the wound care doctor was just there on Friday and she would find out what the orders were. R6's skin and wound note dated 5/1/26 shows, R6 has a wound to his right stump surgical dehiscence. Treatment recommendations: 1. Cleanse with wound cleanser. 2. Apply collagen to base of the wound. 3. Secure with bordered dressing. 4. Change 3 times per week, and PRN (when needed). Assessment/Plan: Changed recommended treatment on 5/1/26. R6's skin and wound note dated 4/24/26 shows, R6's treatment recommendations at that time were xeroform with bordered dressing. R6's skin and wound note dated 4/10/26 & 4/17/26 shows, R6's treatment recommendations at that time were collagen with bordered dressing. Based off R6's skin and wound notes/treatment recommendations were as follows: collagen with bordered dressing ordered 4/10-4/24/26 & 5/1/26 and xeroform with bordered dressing 4/24/26-5/1/26. R6's April 2026 treatment administration record (TAR) shows, RLE (right lower extremity) stump: cleanse with normal saline. Apply collagen to the base of wound. Secure with bordered dressing. Start date 4/15/26, D/C (discontinued) date 4/27/26. The collagen order was not changed until 4/15/26 (5 days late) and R6 missed 1 dressing change with new treatment orders. The same record also shows, the collagen was discontinued on 4/27/26 and R6 received no treatment change that day. (The new order for xeroform was not put in until 4/29/26 (see next statement) and neither treatment was signed out for 4/27/26. R6's April 2026 and May 2026 TAR shows, Right stump: cleanse with normal saline, apply xeroform and cover with a border dressing. Start date 4/29/26, D/C date 5/2/26. The same record shows, R6 received the xeroform treatment on 5/1/26 and not the new treatment for collagen. On 5/6/26 at 11:08 AM, V2 Assistant Director of Nursing (ADON) and V3 ADON from another facility both verified the orders were entered late and R6 did not receive the correct treatment on those days. They also stated, the wound care doctor comes on Fridays and sees residents. They don't get new orders until the next business day, Monday in this case. V2 ADON stated, she is new here and tries to get the orders in as soon as she gets them. R6's Minimum Data Set, dated [DATE] shows, he is cognitively intact. R6's current care plan shows, Focus: Resident has actual impairment to skin integrity (surgical) to blle (bilateral) r/t (related to) amputation of toes and BKA (below knee amputation). Interventions: Treatment as ordered. Cleansing, application of medication, packing and/or dressings change w/wound (with wound) status and progress- See Orders in chart/eTAR (electronic TAR) for current treatments. The facility's wound treatment management (no date) shows, 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. Policy explanation and compliance (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guidelines: 1. Wound treatments will be provided in accordance with physician orders, including cleansed method, type of dressing, and frequency of dressing change.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review the facility failed to ensure a resident with a pressure injury received the prescribed treatment. This applies to 1 of 3 residents (R12) reviewed for wound care/pressure ulcer in the sample of 15. The findings include:R12's face sheet lists his diagnoses to include: diabetes mellitus, type 2, heart failure, chronic kidney disease, pressure ulcer of right buttock, stage 3, major depressive disorder, peripheral vascular disease, atrial fibrillation, coronary artery disease and hypertension. On 5/5/26 at 1:46 PM, V4 Registered Nurse (RN) was changing R12's dressings. He had an open pressure ulcer about the size of a dime on his right buttock. She pulled the dressing off and there was a white piece of collagen and a dressing over it. She stated, that wasn't his dressing and wasn't sure why that was on there. The current order was for hydrocolloid paste and to leave open to air. She stated, because the wound looked like it could benefit from being covered she would call and get different orders. R12's treatment administration record for May shows, Left buttock (wrong buttock), cleanse wound with wound cleanser, apply hydrocolloid dressing to cover wound q3days (every 3 days) and PRN (when needed). Start date 4/29/26. There were no orders for the right buttock. R12's skin and wound note dated 5/1/26 shows, R12 had a pressure ulcer to his right buttock. The treatment recommendations were for hydrocolloid (does not specify a dressing or cream) and leave open to air. On 5/6/26 at 11:08 AM, V2 Assistant Director of Nursing (ADON) stated, she called and clarified the order and it was for a hydrocolloid dressing which is why the TAR showed a dressing. She was not sure why the nurse put a collagen piece then the dressing. She also confirmed it was his right buttock and not left buttock. R12's current care plan shows, Focus: documented pressure ulcer. Interventions: .Provide wound care per treatment order. The same care plan also shows, Focus: Resident HAS area(s) of skin impairment. R (right) buttock stage 3 pressure ulcer, R BKA (below the knee amputation) surgical dehiscence, and abrasion of L (left) dorsal foot. R12 sees the wound Dr. see wound notes for current treatments. Interventions: Administer/apply medications, ointments, creams as orders- see MAR/physician orders. The facility's wound treatment management (no date) shows, 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. Policy explanation and compliance guidelines: 1. Wound treatments will be provided in accordance with physician orders, including cleansed method, type of dressing, and frequency of dressing change. The facility's pressure injury prevention and management policy (no date) shows, Policy: This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure staff did not provide a THC vape pen to a resident for use. This applies to 1 of 15 residents (R6) reviewed for safety in the sample of 15. The findings include:On 5/5/26 at 1:20 PM, V13 laundry/housekeeping stated, he saw V10 former agency Certified Nursing Assistant (CNA) outside with the residents while they were smoking. He saw V10 give R6 a THC (marijuana) vape pen to use. R6 took the pen and used it. He asked other staff members if they knew about it and other staff members stated, he has done it before. He did not report that information to V1 Administrator. He confirmed he knew it was THC by the style of vape pen and they look different than nicotine vape pens. On 5/5/26 at 1:35 PM, V12 Registered Nurse (RN) stated, she had heard that staff were giving THC pens to residents. V13 laundry/housekeeping told her that he saw him give the THC pen to R6. She told him, he needed to report that to V1 Administrator. She has had a few days where residents appear high however, nothing has ever been found. On 5/5/26 at 12:45 PM, V11 Licensed Practical Nurse (LPN) stated, she was aware that staff were giving residents THC pens. She stated, V13 laundry/housekeeping told her, he saw V10 give his THC pen to R6 outside on the patio. On 5/6/26 at 1:05 PM, R6 denied, V10 former agency CNA gave him a THC pen. He stated, he has given him his nicotine vape to smoke but never a THC pen. He has used the nicotine vape pen when he gave it to him. On 5/6/26 at 8:16 AM, V10 former agency CNA denied, giving any THC pens to residents. He said he smokes marijuana at home but not at work.On 5/6/26 at 12:06 PM, V1 Administrator stated, V10 former agency CNA was DNR'd (do not return) from the facility for allegations of sleeping while working and an incident where he let residents smoke outside of their scheduled smoke time. She was not aware V10 was giving THC pens to R6. R6's Minimum Data Set, dated [DATE] shows, he is cognitively intact. The facility's safety for residents with substance use disorder (no date) shows, Policy: It is the policy of this facility to create an environment that is as free of accident hazards as possible, for residents with a history of substance use disorder.The facility's employee handbook & code of conduct dated 12/1/23 shows, Drug and alcohol workplace testing and substance abuse: Our company has a responsibility to provide a safe, healthy, and productive environment for our residents and employees. The use of illegal drugs and alcohol has an adverse effect on employee performance, jeopardizes the safety of employees, residents, and visitors, and constitutes a risk to the overall interests of the company.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review the facility failed to manage a resident's pain by not administering analgesic pain medications as prescribed for 1 of 3 residents (R8) reviewed for pain management in the sample of 15.The findings include:A physician order for R8 dated 4/20/26 showed, Hydrocodone-Acetaminophen (Norco/narcotic pain medication) 5/325 milligrams, give 1 tablet every 6 hours as needed for pain.R8's provider note dated 4/21/26 showed resident has continued complaints of right foot/heal pain, which she states has already had imaging of and is awaiting insurance approval for CT scan. She currently has orders for Hydrocodone-acetaminophen for pain as needed.On 5/4/26 at 10:32 AM, R8 was in bed. R8 stated she didn't feel well because she had not received any Norco since last Thursday (4/30/26). R8 stated, I have rheumatoid arthritis, fibromyalgia, and pain in my foot. I usually take 2 Norco a day for my pain. I haven't gotten it (Norco) since last week because they say they ordered my medication, but it hasn't been delivered yet. R8 rated her current pain level as a 9/10 however, R8 appeared calm, was not restless, and appeared drowsy at times. R8's April 2026 and May 2026 Medication Administration Records (MAR) showed R8 last received a dose of Norco on 4/30/26. R8's May MAR showed no doses of Norco were administered to R8 from 5/1/26-5/4/26. On 5/4/26 at 10:39 AM, V6 Registered Nurse stated, (R1) is out of her Norco. Her last dose was last week. It looks like the Norco was ordered on 4/20/26 but it hasn't been delivered from the pharmacy yet. I am not sure what the delay is. (R1) did complain of pain this morning, so I gave her a Flexeril (muscle relaxant medication). I know its not the same as Norco. When V6 was asked if the facility had a Pyxis machine (electronic medication dispensing machine) that she could get a dose of Norco from for R8, V6 stated, I am agency. I asked if the facility had a Pyxis and I didn't really get an answer, so I am not sure. On 5/4/26 at 11:01 AM, V2 Assistant Director of Nursing stated staff are to reorder medications when a resident has seven doses left so the facility does not run out of the medication and pharmacy has time to deliver the medications. V2 stated the facility's pharmacy makes deliveries to the facility daily. V2 stated she was unaware the facility had not received R8's Norco. V2 stated, Staff are to notify me or (V1 Administrator) if we run out of medications for a resident. V2 stated the facility does have a Pyxis system that nursing could have pulled doses of Norco from for R8. V2 stated, I am not sure why nursing didn't pull Norco from the Pyxis for (R8) over the weekend.The facility's Pain Management policy (undated) showed, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.The facility's Medication Reordering policy (undated) showed, It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident. Acquisitions of medications should be completed in a timely manner to ensure medications are administered in a timely manner. Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication.

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	05/05/2026

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on interview and record review the facility failed to monitor and prevent a resident, with a diagnosis of dementia, from wandering into other resident rooms for 1 of 1 residents (R1) reviewed for dementia care in the sample of 15. The findings include:R1's current care plan showed R1 was severely cognitively impaired due to her diagnosis of dementia. The plan showed R1 was ambulatory and wandered throughout the facility. The plan showed, Resident wandering and rearranging another resident's room. Resident likes to touch, hug, or kiss others. Resident has a history of being physically aggressive. The plan showed staff were to closely monitor and intervene when needed to prevent R1 from wandering into other resident rooms by offering R1 structured activities and pleasant diversions. R1's health status notes dated 2/22/26 and 2/26/26 showed R1 was found in a resident's room (R4), attempting to take belongings from R4. On 2/22/26, R1 and R4 got into a verbal argument due to R1 being in R4's room. R1 attempted to hit R4 but was unsuccessful as staff intervened in time. On 2/26/26, R1 again entered R4's room and attempted to take belongings from R4's room. R1 and R4 began to argue. The notes showed R1 hit R4 before staff intervened. On 5/4/26 at 8:46 AM, R4 stated R1 goes into everyone's room and takes things. This happens every day. One time she came in here and tried to take my things. I am helpless and can't get out of bed, so I started yelling at her and yelling for help (from staff). R4 stated R1 told R4 I will show you and then R1 punched R4 in the arm. R4 stated staff did not enter her room until after R1 had punched R4.On 5/4/26 at 8:42 AM, R3 stated R1 wanders into my room a lot. I just talk to her and eventually she leaves.On 5/4/26 at 8:51 AM, R7 stated, (R1) wanders around every day and goes into rooms and takes things. We have to watch out for her, so she doesn't take our stuff.On 5/4/26 at 9:27 AM, R9 stated, (R1) wanders into my room all the time. She comes right up to your face, like there is no personal space. Last week, she came in and tried to take my roll of my tray. I swatted at her and shooed her away. R9 stated no staff were present during the incident. On 5/4/26 at 9:50 AM, V4 Registered Nurse stated staff are aware of R1's wandering behaviors. V4 stated, (R1) does wander into resident rooms and tries to take things. We try to watch her and keep her in activities.On 5/4/26 at 10:00 AM, V9 Certified Nursing Assistant stated R1 was a grabber. V9 stated R1 will go into rooms and grab resident's things. We try to keep her busy and watch her.On 5/4/26 at 10:05 AM, V5 Social Services stated R1 has a known behavior of wandering into other resident's rooms and taking belongings from those rooms. V5 stated staff should be monitoring R1 and intervening when R1 attempts to enter other residents' rooms. The facility's Dementia Care policy (undated) showed, It is the policy of this facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being. Care and services will be person-centered and reflect each resident's individual goals while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.The facility's Elopements and Wandering Residents policy (undated) showed, This facility ensures that residents who exhibit wandering behaviors and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering and elopement risk.