STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Bella at Clifton	1190 E 2900 North Road Clifton, IL 60927

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 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 34058 Based on interview and record review, the facility failed to develop their abuse prevention policy to include a definition of abuse to include abuse facilitated or enabled by the use of technology. This failure has the potential to affect all seventy residents residing in the facility. Findings include: The facility's policy Abuse, Neglect, Exploitation, and Misappropriation Prevention Program dated August 2024, does not include a prohibition of abuse facilitated or enabled by the use of technology. On 3/26/25 at 12:59 PM, V1, Administrator, acknowledged and confirmed the abuse prevention policy dated August 2024 was the most recent revision and did not include the prohibition of abuse utilizing technology such as video recording of residents in compromising situations. On 3/26/25 at 4:15 PM, V6, [NAME] President of Clinical Operations, stated she could put the prohibition against the use of technology into the facility policy right now. The facility's Resident Roster dated 3/25/25 documents 70 residents residing in the facility.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 34058 Based on observation, interview, and record review, the facility failed to implement a plan of care to reduce resident intrusion of privacy and resulting in aggression. This failure has the potential to affect two residents (R1 and R2) out of three reviewed for allegations of abuse on the sample list of three. Findings include: On 3/25/25 at 11:05 AM, V1, Administrator, stated there had been an incident between R1 and R2 on 3/21/25 when R2 wandered into R1's room, R1 had gotten out of bed to redirect R2 out of his room, and both residents ended up falling to the floor with R2 landing on top of R1. R2's Nursing Progress Note dated 3/20/25 documents R2 had exited his bathroom in the wrong direction on this date, entering the adjoining room of R1 and upsetting R1. This same note documents an interdisciplinary team review of this incident and formulated a plan of care to place a sign in the bathroom to indicate to R2 which bathroom door to exit to go into his own room. On 3/25/25 at 2:30 PM, there was not any sign in the adjoining bathroom between R1's and R2's room to indicate to R2 which bathroom door to exit to return to his own room rather than R1's room. On 3/26/25 at 1:45 PM, V2, Director of Nursing, stated she had participated in the interdisciplinary team review and the team did decide to place a sign in the bathroom between R1's and R2's rooms to indicate which direction R2's room was from the bathroom. V2 stated the sign did not get placed and then this other incident happened between R1 and R2 when R2 wandered into R1's room during the night. V2 continued to state the facility did install a locking doorknob cover on the bathroom door leading to R1's room so that bathroom door could not be opened from inside the bathroom. V2 stated when R1 uses the bathroom he has to leave the door open so he can return to his own room when he is finished. On 3/25/25 at 1:50 PM, V6, [NAME] President of Clinical Operations, was instructing V2 to resolve off R2's care plan for the doorknob cover and implement placement of the sign according to the interdisciplinary team decision. V2 then stated there wasn't any reason the facility couldn't do both the sign and the doorknob.