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	04/15/2025

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 0600 Level of Harm - 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** 40385 Based on observation, interview, and record review the facility failed to protect a resident's (R1) right to be free from physical abuse by another resident (R2). This failure affects two (R1, R2) of seven residents reviewed for abuse in the sample list of 14. This failure resulted in R2 abusing R1, causing R1 to experience psychosocial harm as evidenced by crying and fear of R2. Findings include: On 4/14/25 at 8:14 AM R1 was in a wheelchair and slowly propelled herself into her room. R1 stated R1 wishes another resident, R2, wasn't here in the facility. R1 stated a couple weeks ago around 5:00 PM, while in the main dining room, R2 hit R1 in the back of the neck. R1 demonstrated this with an open palm. R1 stated this caused R1 to have neck pain for a few days after the incident. R1 stated this incident was witnessed by V4 Certified Nursing Assistant (CNA). R1 stated R1 is afraid of R2 and every time R2 goes past R1, R1 gets all shaky and nervous. R1 stated R2 has Alzheimer's and R1's mother was the same way. R1 stated R1's mother used to spank R1, pinch R1, and pull R1's hair whenever R1 had an incontinence accident; and this incident brings back those memories. On 4/14/25 at 11:45 AM R2 was walking by herself, pushing a wheelchair out of the activity room. At 11:53 AM R2 was interviewed regarding the incident with R1. R2 did not recall the incident and was confused. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is cognitively intact, requires substantial/maximal assistance from staff for transfers, and does not walk. R2's Admission MDS dated [DATE] documents R2 has severe cognitive impairment, physical/verbal/other behaviors noted one to three days during the review period, and these behaviors put others at risk for injury and significantly disrupts care or living environment. R2's Nursing Note dated 3/29/2025 at 5:30 PM documents R2 was near the nurse's station yelling shut the F**** (expletive) up, motherf****** (expletive) and banging on the walls. Attempts at redirection were unsuccessful. R2's Behavior Monitoring and Intervention Report dated 3/17/25-4/15/25 documents R2 had aggression towards others on 10 days. The facility's Daily Nursing Schedules dated 4/1/25 and 4/2/25 document V4 CNA worked the evening shift and was assigned to monitor the main dining room. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 4/14/25 at 9:14 AM V4 CNA stated on an unidentified date within the last month, around 4:30-5:00 PM, R1 and R2 were in the dining room. V4 stated R2 wheeled past R1 in her wheelchair, R2's wheelchair got stuck and couldn't get past R1. V4 stated R2 got upset with R1 and smacked R1 in the back of the neck with R2's hand. V4 stated V4 ran over there as fast as she could to get R1 out of the way. V4 confirmed V4 considered R2's actions as abuse. V4 stated R2 has hit staff during cares, has outburst and swats at people as they walk past her. V4 stated R1 cries now every time R1 sees R2 and tells the staff that R2 had hit R1. On 4/14/25 at 9:28 AM V18 Licensed Practical Nurse (LPN) stated it was reported to V18 that R1 does not like R2 around and freaks out. V18 stated V18 did not witness but was told that R2 had hit R1 on the back of the neck in the dining room, and this was reported by an unidentified CNA on an unidentified date. V18 stated when R1 has an experience, R1 doesn't forget it. On 4/14/25 at 9:50 AM V21 Activity Director stated on the morning of 4/4/25, R1 told V21 that R2 had smacked R1 in the back of the head. V21 stated V21 had been off work that week and returned on 4/4/25 and the incident happened sometime that week. V21 stated R1 said R1 did not want to be around R2, and inferred that R1 was afraid of R2. V21 described R1 as being sad when R1 reported this. V21 stated R1's mother had dementia and would spank R1 when R1 was incontinent and R1 is very fearful due to her history with her mother and not having the ability to run away from others. V21 stated R1 does not have any memory problems. On 4/14/25 at 12:44 PM V8 LPN stated there was a day within the last couple weeks that R1 would not go into the activity room because of R2. V8 stated R1 was crying but V8 could not understand R1 or why R1 was upset with R2. V8 stated V8 took R1 to her room to calm down. The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated as revised March 2025, documents residents have the right to be free from abuse and abuse includes the willful infliction of injury with resulting physical harm, pain or mental anguish.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to timely report an allegation of resident to resident physical abuse to the administrator and to the state survey agency for two (R1, R2) of seven residents reviewed for abuse in the sample list of 14. Findings include: On 4/14/25 at 8:14 AM R1 stated a couple weeks ago around 5:00 PM, while in the main dining room, R2 hit R1 in the back of the neck. R1 demonstrated this with an open palm. R1 stated this caused R1 to have neck pain for a few days after the incident. R1 stated this incident was witnessed by V4 Certified Nursing Assistant (CNA). R1 stated R1 is afraid of R2 and every time R2 goes past R1, R1 gets all shaky and nervous. R1 stated R2 has Alzheimer's and R1's mother was the same way. R1 stated R1's mother used to spank R1, pinch R1, and pull R1's hair whenever R1 had an incontinence accident; and this incident brings back those memories. R1 stated R1 reported this incident to V1 Administrator and V7 Former Director of Nursing (DON) the next morning. R1's Minimum Data Set (MDS) dated [DATE] documents R1 is cognitively intact, requires substantial/maximal assistance from staff for transfers, and does not walk. R2's Admission MDS dated [DATE] documents R2 has severe cognitive impairment, physical/verbal/other behaviors noted one to three days during the review period, and these behaviors put others at risk for injury and significantly disrupts care or living environment. R2's Nursing Note dated 3/29/2025 at 5:30 PM documents R2 was near the nurse's station yelling shut the F**** (expletive) up, motherf****** (expletive) and banging on the walls. Attempts at redirection were unsuccessful. R2's Behavior Monitoring and Intervention Report dated 3/17/25-4/15/25 documents R2 had aggression towards others on 10 days. V22 Social Service Director's handwritten note dated 4/7/25 documents R1 came to V22's office and reported that R1 did not like R2 because R2 hit R1's head. R1 reported that R1 and R2 were in the dining room eating and R2 reached across and their heads bumped each other. V1 Administrator's written statement dated 4/7/25 documents V22 reported that R1, who was tearful, wanted to speak with V1. R1 reported that the night prior, while in the dining room, R2 reached over R1 and bumped R1 on the front of her head, and R1 did not think R2's actions were done on purpose. R1 told V1 that R1 did not want R2 in the facility anymore. On 4/14/25 the facility's abuse investigative files between December 2024 and April 2025, provided by V1 Administrator, were reviewed. There was no abuse investigative file for any altercations between R1 and R2, and no documentation that the facility reported this altercation to the state survey agency. There is no documentation of this incident in R1's or R2's medical records. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/14/25 at 9:14 AM V4 CNA stated on an unidentified date within the last month, around 4:30-5:00 PM, R1 and R2 were in the dining room, R2 wheeled past R1 in her wheelchair, R2's wheelchair got stuck and R2 couldn't get past R1. V4 stated R2 got upset with R1 and smacked R1 in the back of the neck with R2's hand. V4 stated V4 ran over there as fast as she could to get R1 out of the way. V4 confirmed V4 considered R2's actions as abuse. V4 stated V4 reported this incident to V18 Licensed Practical Nurse (LPN) at an unidentified time on the date of the incident. V4 stated V1 Administrator is the facility's abuse coordinator but V4 did not report this incident to V1. V4 stated V4 followed the chain of command by reporting to the nurse, V18. On 4/14/25 at 9:28 AM V18 LPN stated staff have mentioned that R1 does not like R2 around and freaks out. V18 stated V18 did not witness but was told by an unidentified CNA on an unidentified date that R2 hit R1 on the back of the neck while in the dining room. V18 stated V18 did not report this to V1 since management staff/administration was already aware of the incident. On 4/14/25 at 9:50 AM V21 Activity Director stated on the morning of 4/4/25, R1 told V21 that R2 had smacked R1 in the back of the head. V21 had been off work that week and returned on 4/4/25, and the incident happened sometime that week. V21 stated R1 said R1 did not want to be around R2, and V21 inferred that R1 was afraid of R2. V21 stated administration/management was already aware of R1's allegation because that morning V11 Maintenance Director told V21 it was discussed in the morning meeting that R1 and R2 had to be kept separated. On 4/14/25 at 11:03 AM V11 Maintenance Director stated it was discussed in morning meeting within the last two weeks to keep R1 and R2 away from each other. V11 stated he didn't know any other details. On 4/14/25 at 12:54 PM V7 Former DON stated on an unidentified date an unidentified staff person reported that R2 had touched R1, but V7 was unable to recall any additional details. V7 stated it happened during the evening when management staff weren't at the facility and V7 was unsure if V1 Administrator was aware of the incident. On 4/14/25 at 2:08 PM V10 (R1's Family) stated on 4/11/25 R1 was in the hallway crying and V10 took R1 to her room. V10 stated R1 told V10 that another resident, R2, hit R1 in the back of the neck; and V10 reported this to V7 Former Director of Nursing. On 4/14/25 at 9:31 AM V1 Administrator stated about two weeks ago it was reported that R2 had touched R1, V1 spoke to R1 and determined it was an accidental bumping of heads as R2 leaned across the back of R1's wheelchair. V1 described R1 as being emotional when V1 spoke with her and was unsure that contact was even made. V1 stated it wasn't abuse since it wasn't intentional and V1 did not report this incident to the state survey agency. V1 stated staff are suppose to report abuse immediately to V1 and no staff had reported that R2 smacked R1 on the back of the neck. V1 stated that would have been reported as an abuse allegation. The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated as revised March 2025, documents residents have the right to be free from abuse and abuse includes the willful infliction of injury with resulting physical harm, pain or mental anguish. This policy documents the facility will identify and investigate all possible incidents of abuse and report abuse allegations within the federally required time frames.

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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** 52228 Based on Observation, Interview and Record Review the facility failed to properly perform a mechanical lift transfer resulting in a fall, failed to document falls in the medical record, investigate falls and develop/implement post fall interventions for two (R2,R3) of three residents reviewed for falls in a sample list of 14. Findings Include: Facility Policy dated August 2024 documents that two nursing assistants are needed to safely move a resident with a full mechanical lift. This policy also documents that the full mechanical lift may be used for tasks that require, transferring a resident from bed to the chair, and lateral transfers. 1.) R3 Minimum Data Set from 2/12/2025 documents R3 has severe cognitive impairment with substantial/maximum assistance. R3's Nursing Note dated 4/1/25 at 8:38 AM R3 had a witnessed fall. R3 was on the floor by his chair with his legs extended out in front of him and the Certified Nursing Assistant (CNA) stated R3 unclamped the sling from the lift and was then lowered to floor without hitting his head. On 4/14/2025 at 9:25AM, R3 was sitting in a laid-back wheelchair in his room with his eyes closed. At 12:20PM on 4/14/2025. V6 CNA stated that while transferring R3 to his lying back wheelchair by mechanical lift, R3 grabbed the sling that hooked on the mechanical lift and detached it from the mechanical lift. V6 stated that when she noticed R3 was unhooked she lowered R3 to his reclining chair which was leaning forward and R3 slid out of the wheelchair. V6 stated that V6 transferred R3 by herself. V6 stated , I should have asked for help, but everyone was too busy. On 4/15/2025 at 1:30PM V5 CNA and V9 CNA transferred R3 from the reclining wheelchair into bed using a full mechanical lift. R3 had no behaviors and wasn't reaching for the straps to unlock the sling from the mechanical lift. V9 stated V9 switched out R3's chair on 4/2/2025 due to the wheelchair being broken and it was leaning forward in an upright position, and would not recline. On 4/15/2025 at 3:25PM V2 (Director of Nursing) stated that all CNA's are required to complete transfer training upon hiring. V2 also stated that two-person assist is required with all mechanical lifts when transferring. 40385 2.) R2's Admission Minimum Data Set, dated dated dated [DATE] documents R2 has severe cognitive impairment, requires staff assistance with activities of daily living, has physical/verbal/other behaviors noted one to three days during the review period, and these behaviors put others at risk for injury and significantly disrupts care or living environment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's active Care Plan documents R2 is at risk for falls due to impaired cognition, safety awareness, and balance. This care plan does not document a post fall intervention for R2's fall on 3/26/25. R2's Fall Report dated 2/17/25 at 9:00 PM documents R2 was found on the floor next to her bed. This fall is not documented in R2's medical record. R2's Fall Report dated 3/26/25 at 8:30 PM documents a Certified Nursing Assistant (CNA) attempted to transfer R2 into a wheelchair to transport to the restroom in the hallway, R2 refused care, R2 hit the CNA, R2 lost her balance and fell hitting her head on the handrail. R2 did not have any injuries.This fall is not documented in R2's medical record. The investigative file for this fall, provided by V2 Director of Nursing (DON) does not document which CNA was involved in R2's fall, or that this fall was investigated to determine a root cause and implement a post fall intervention. On 4/15/25 at 6:15 AM V12 Licensed Practical Nurse (LPN) stated staff had just toileted and assisted R2 to bed prior to R2's fall on 2/17/25. V12 stated V12 notified R2's family and physician. V12 confirmed V12 did not document this fall in R2's medical record. On 4/15/25 at 9:37 AM V24 LPN stated R2 was in the hallway with V4 CNA when R2 fell on [DATE]. V24 stated V24 did not witness the fall and described R2 as being at her baseline, cursing and combative with staff when attempting to redirect or provide cares. V24 stated R2 just gets more agitated so we try to reapproach R2 later. V24 stated staff had not mentioned if R2 was resistive or agitated prior to R2's fall. On 4/15/25 at 10:13 AM V4 confirmed V4 was the CNA assisting R2 during the fall on 3/26/25. V4 stated V4 was pulling R2 in a wheelchair backwards down the hallway, R2 grabbed the handrail and flipped out of the chair. V4 stated V4 pulled R2's wheelchair backwards due to R2 resisting and planting her feet, but R2 had to be changed because it was the end of shift. V4 was asked about any alternative approaches or interventions used during this incident. V4 stated R2 is always combative and resistant to toileting. V4 stated staff usually ask if R2 has to use the bathroom, but due to R2's dementia R2 has difficulty understanding words. V4 denied that any visual cues or aides have been trialed for R2. V4 stated R2 seems to do well for V25 CNA, but V4 did not ask for V25 to assist with R2's toileting cares that day. V4 confirmed no alternative approaches were used. On 4/15/25 at 6:33 AM V2 DON stated R2 fell on [DATE] and a post fall intervention had not been developed/implemented. At 6:58 AM V2 stated the initial fall note should be entered in the risk management as a progress note that transfers into the resident's chart. V2 verified there is no initial note documenting the details of R2's fall on 3/26/25. V2 stated V2 was unsure which CNA was assisting R2 during the fall on 3/26/25. At 10:40 AM V2 confirmed R2's fall on 2/17/25 was not documented in R2's medical record and confirmed R2's 3/26/25 fall was not investigated. V2 stated V7 Former DON was responsible for the fall investigations at that time.

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F 0742 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 mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview and record review the facility failed to identify triggers, develop a care plan and implement interventions and services to address a past history of abuse (R1). This failure affects three (R1, R2, R14) of seven residents reviewed for abuse in the sample list of 14. Findings include: The facility's Trauma-Informed and Culturally Competent Care policy dated August 2022 documents traumatic events which may affect residents during their lifetime includes physical and emotional abuse, and trauma survivors who transition to institutional living may experience triggers and re-traumatization. Triggers are individualized, but may include a lack of privacy or confinements in a crowded or small space, exposure to loud noises, exposure to bright or flashing lights, certain sights or objects, or sounds, smells and physical touch. This policy documents to use screening and assessment tools in collaboration with the Quality Assurance Performance Improvement Committee and use community organizations for services, referrals, training and information. Screen residents for exposure to traumatic events, including history of trauma type, severity, and duration; trauma-related or dissociative symptoms; behavioral concerns; protective factors; resources available. This policy documents this screening will identify the need for further assessment and care, assess for symptoms related to trauma, identify triggers, and utilize licensed and trained clinicians to conduct trauma assessments. This policy documents to develop individualized care plans that address past trauma in collaboration with the resident and their family, identify and decrease exposure to triggers that may re-traumatize the resident, develop a plan that embraces strengths and further learning rather than dictating a plan to change the behavior, and avoid a one-size-fits-all approach. On 4/14/25 at 8:14 AM R1 was in a wheelchair and slowly propelled herself into her room. R1 stated R1 wishes another resident, R2, wasn't here in the facility. R1 stated a couple weeks ago around 5:00 PM, while in the main dining room, R2 hit R1 in the back of the neck. R1 demonstrated this with an open palm. R1 stated this caused R1 to have neck pain for a few days after the incident. R1 stated this incident was witnessed by V4 Certified Nursing Assistant. (CNA) R1 stated R1 is afraid of R2 and every time R2 goes past R1, R1 gets all shaky and nervous. R1 stated R2 has Alzheimer's and R1's mother was the same way. R1 stated R1's mother used to spank R1, pinch R1, and pull R1's hair whenever R1 had an incontinence accident; and this incident brought back those memories. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Minimum Data Set (MDS) dated [DATE] documents R1 is cognitively intact, requires substantial/maximal assistance from staff for transfers, and does not walk. R1's active care plan documents R1 has episodes of anxiety, anger poor impulse control, crying, and child like tantrums. This care plan documents R1 is at high risk for abuse/ and or neglect due to ineffective coping skills related to cognitive deficit and decreased impulse control. Interventions include to assess for support systems and additional resources, discuss alternative coping strategies, provide a safe environment, provide emotional support, evaluate response to interventions, trauma informed support as needed, and refer for psychiatric evaluation. R1's care plan includes an intervention dated 9/5/24 to keep R1 away from other residents that seem to trigger R1's behaviors. R1's care plan does not include R1's history of abuse, associated triggers related to this past abuse, or interventions. R1's care plan documents R1's diagnoses include paraplegia, anxiety disorder, cerebral palsy, genetic related intellectual disability, and major depressive disorder with sever psychotic symptoms. R1's Social Service Comprehensive assessment dated [DATE] documents R1 has a history of abuse and or neglect, and exposure to trauma. This assessment does not document any additional details regarding this abuse/trauma. R1's Psychiatry Note dated 4/7/25, recorded by V23 Nurse Practitioner, documents R1 has a history of depression and anxiety, R1 reported her mood as good, and the staff reported no maladaptive behaviors. This note documents under family history, R1 did not know if there was any family history or psychiatric issues in her family, R1's chart did not indicate family history and there was no family at the bedside. R1's Nursing Note dated 4/9/2025 at 9:41 AM documents during breakfast R1 was getting agitated about another resident (R14) being in the wrong dining room. The nurse explained that R14 was not bothering anyone and was sitting quietly and R14 would be removed from the dining room later. The nurse left the dining room and later heard R1 yelling and screaming in the hallway about other residents. The nurse attempted to calm R1 and R1 began slapping and ripping the nurse's stethoscope off of her neck. The nurse calmly asked R1 to calm down and told R1 that R1 would have to go to her room until R1 was calm. R1 then began to cry and then calmed down. R1 was then taken to the dining room and explained that this behavior couldn't continue, R1 would need to remain calm if R1 wanted to be in the dining room. R1's Nursing Note dated 4/14/25 at 10:34 AM documents a psychosocial assessment for a resident to resident physical altercation and that R1 had new onset of increased behaviors including crying, tearfulness, fearfulness, anxiety, agitation, yelling and anger. This note documents R1 has a history of physical/emotional trauma and triggers include change in routine and living arrangement. Interventions include one to one with staff. On 4/14/25 at 9:14 AM V4 CNA confirmed R1's and R2's physical altercation as described by R1. V4 stated R1 cries now every time R1 sees R2 and tells the staff that R2 had hit R1. On 4/14/25 at 9:28 AM V18 Licensed Practical Nurse (LPN) stated when R1 has an experience, R1 doesn't forget it. V18 stated R2 is very loud/vocal and cusses, which makes R1 anxious. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/14/25 at 9:50 AM V21 Activity Director stated on the morning of 4/4/25, R1 told V21 that R2 had smacked R1 in the back of the head. V21 stated R1 said R1 did not want to be around R2, and V21 inferred that R1 was afraid of R2. V21 stated R1's mother had dementia and would spank R1 when R1 was incontinent and R1 is very fearful due to her history with her mother and not having the ability to run away from others. V21 stated V21 has told the CNAs that it's very important to be mindful of their approach with R1, especially with R1's incontinence, due to R1's history of abuse. On 4/14/25 at 11:04 AM V22 Social Services Director stated V22 started working in the facility in January 2025 and per unidentified coworkers, R1 likes to fixate on individual residents. V22 stated V22 thinks R1's mother treated R1 like a child, making R1 feel belittled, and R1 does not like when staff bring up her mother. V22 stated this would be care planned, as well as a history of abuse and included in the social services comprehensive assessment. V22 stated V3 Care Plan Coordinator is responsible for updating this on the care plan. V22 stated R1 would know about R1's history of abuse. On 4/14/25 at 11:33 AM V3 stated R1's mother was verbally abusive when R1 had accidents, and was unsure about physical abuse. V3 stated R1's family has discussed this during care plan meetings and V22 is responsible for obtaining this information. V3 confirmed this information should be care planned. V3 stated V3 did not see anything specific to R1's past history of abuse in R1's care plan. At 12:13 PM V3 stated R1's care plan includes an intervention to keep triggering residents away from R1, but no other new interventions have been implemented. V2 Director of Nursing stated we just try to keep the triggering residents away from R1. On 4/14/25 at 12:44 PM V8 LPN stated there was a day within the last couple weeks that R1 would not go into the activity room because of R2. V8 stated R1 was crying but V8 could not understand R1 or why R1 was upset with R2. V8 stated V8 took R1 to her room to calm down. V8 confirmed V8 documented R1's 4/9/25 nursing note. V8 stated R14 was the other resident mentioned in the note. V8 stated R1 has a history of being upset by other residents, just overall not happy with them. V8 stated R1 gets upset and cries and we take R1 to her room to calm down. On 4/14/25 at 2:08 PM V10, R1's Family, stated R1's/V10's mother spoke harshly to R1. V10 stated R1 later reported that their mother spanked R1 when R1 was incontinent and was rough with R1. V10 stated family started staying with R1 for three months until nursing home placement was found. V10 stated when R1 admitted to the facility several years ago, V10 spoke with the staff about R1's abuse and R1's fear of how staff would react when R1 had incontinence/accidents. On 4/15/25 at 10:33 AM V5 CNA stated R1 has a learning disability and the staff don't know how to care for R1. V5 stated V5 was unsure if R1 has a history of family abuse, R1 has never mentioned that to V5. (continued on next page)

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	146085	A. Building B. Wing	04/15/2025

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LA Bella at Clifton	1190 E 2900 North Road Clifton, IL 60927

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at 11:08 AM V23 Nurse Practitioner stated R1 has been receiving psychiatry services through V23's company since at least 2022 and V23 has been seeing R1 since January 2025. V23 stated R1 has mild intellectual disability, V23 reviewed R1's chart and stated V23 did not see anything documented about a past history of abuse or trauma or a diagnosis of Post Traumatic Stress Disorder (PTSD). V23 stated PTSD would be past trauma or physical/verbal aggression that causes the resident to have anxiety and/or paranoia. PTSD could cause R1 to be reminded of her mother by other residents. V23 stated no one had reported that R1 had a history of abuse by her mother and V23 looks at the resident's medical record to determine past history and staff should also report this. V23 stated R1 had never brought up this history during V23's visits. V23 stated if V23 was made aware, V23 would have recommended Licensed Clinical Social Worker (LCSW) psychotherapy sessions, possible medication adjustments, and try to identify R1's triggers. V23 stated it would be helpful for the facility to identify R1's triggers related to R1's past history of abuse. V23 stated V23 will follow up and evaluate R1 for a diagnosis of PTSD. On 4/15/25 at 11:15 AM V2 stated R1 has not had psychotherapy sessions within the last six months. V2 stated the facility recently has a new LCSW providing these services, but R1 has not yet been seen.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview and record review the facility failed to care plan, identify targeted behaviors and develop/implement personalized interventions to address dementia related behaviors (R2). This failure affects two (R1, R2) of seven residents reviewed for abuse in the sample list of 14. Findings include: The facility's Dementia - Clinical Protocol dated November 2018 documents residents with dementia will have a resident-centered care plan to maximize remaining function and quality of life and the resident's needs will be communicated to direct care staff through care plan conferences, shift communication, and through written documentation such as nursing notes. This policy documents staff should report progressive or persistent worsening of symptoms and increased staff support to the Interdisciplinary Team (IDT), the physician will order appropriate interventions to address significant behavioral or psychiatric symptoms, and the IDT will adjust interventions on the care plan depending on the resident's response to the interventions. On 4/14/25 at 8:14 AM R1 stated a couple weeks ago around 5:00 PM, while in the main dining room, R2 hit R1 in the back of the neck. R1 demonstrated this with an open palm. R1 stated this incident was witnessed by V4 Certified Nursing Assistant (CNA). On 4/14/25 at 8:30 AM R1's and R2's rooms were located on the same hall of the facility. On 4/14/25 at 11:45 AM R2 was walking by herself, pushing a wheelchair out of the activity room. At 11:53 AM R2 was interviewed regarding an incident with R1. R2 did not recall the incident with R2 and was confused. R2's Admission Minimum Data Set, dated dated dated [DATE] documents R2 has severe cognitive impairment, physical/verbal/other behaviors noted one to three days during the review period, and these behaviors put others at risk for injury and significantly disrupts care or living environment. R2's active Care Plan documents R2 is or has the potential to be physically aggressive related to dementia (2/7/25) and interventions (2/7/25) include assess for resident's needs, monitor behaviors and attempt to determine the underlying cause, report signs of posing a danger to herself or others, provide a non-confrontational environment for care, intervene before agitation escalates, guide away from source of distress, staff to walk calmly away and approach later, explain care in terms the resident can understand, give choices about care and activities as appropriate, intervene as needed to protect the rights and safety of others, approach in a calm manner, divert attention, remove from the situation and take to another location as needed. R2's care plan documents R2 has impaired thought process and interventions include making eye contact when speaking to R2, reduce distractions, use simple/direct sentences, provide necessary cues, segment tasks into one step at a time, and stop and return if R2 is agitated. R2's care plan has not been updated to include R2's physical altercation with R1 or that R2 is resistive with cares. R2's Nursing Notes document the following: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/20/25 at 5:44 PM R2 refused wound care and medications, and R2 cursed at the nurse. On 3/29/2025 at 5:30 PM R2 was at the nurses station yelling at other residents, shut the f*** (expletive) up, motherf******! R2 was banging on the walls and staff attempts at redirection was unsuccessful. On 4/9/2025 at 6:36 PM R2 refused evening medications, refused care from staff, and cursed at staff. R2 was exit seeking and making statements as if R2 was working in a factory dictating to staff and other residents that they needed to get on the line and perform tasks. R2 appeared to calm down when allowed to walk around the facility on R2's own, away from staff and residents. R2's Behavior Monitoring and Intervention Report dated 3/17/25-4/15/25 is generic and lists a variety of behaviors and interventions, but does not identify which behaviors are specific to R2 and personalized nonpharmacological interventions or approaches for R2's behaviors. This report documents R2 has behaviors of wandering/exit seeking, refusing cares, and physical and verbal aggression towards others including kicking, hitting, grabbing, pushing, scratching, cursing, screaming, and threatening. R2's Fall Report dated 3/26/25 at 8:30 PM documents a CNA attempted to transfer R2 into a wheelchair to transport to the restroom in the hallway, R2 refused care, R2 hit the CNA, R2 lost her balance and fell hitting her head on the handrail. R2 did not have any injuries. On 4/14/25 at 9:14 AM V4 CNA stated on an unidentified date within the last month, around 4:30-5:00 PM, R1 and R2 were in the dining room. V4 stated R2 wheeled past R1 in her wheelchair, R2's wheelchair got stuck and R2 couldn't get past R1. V4 stated R2 got upset with R1 and smacked R1 in the back of the neck with R2's hand. V4 stated V4 ran over there as fast as she could to get R1 out of the way. V4 confirmed V4 considered R2's actions as abuse. V4 stated R2 has hit staff during cares, has outburst and swats at people as they walk past her. V4 stated staff try to engage R2 in activities or just let R2 roam, and staff try to monitor R2 so that R2 does not go into the dining room when R1 is in there. On 4/15/25 at 10:13 AM V4 confirmed V4 was the CNA assisting during R2's fall on 3/26/25. V4 stated V4 was pulling R2 in a wheelchair backwards down the hallway, R2 grabbed the handrail and flipped out of the chair. V4 stated V4 pulled R2's wheelchair backwards due to R2 resisting and planting her feet, but R2 had to be changed because it was the end of shift. V4 was asked about any alternative approaches or interventions used during this incident. V4 stated R2 is always combative and resistant to toileting. V4 confirmed no alternative approaches were used. V4 stated staff usually ask if R2 has to use the bathroom, but due to R2's dementia R2 has difficulty understanding words. V4 denied that any visual cues or aides have been trialed for R2. V4 stated R2 seems to do well for V25 CNA, but V4 did not ask for V25 to assist with R2's toileting cares that day. On 4/14/25 at 12:44 PM V8 LPN stated R2 yells/screams/cusses in common areas with other residents present and R2 thinks R2 is working in a factory and directs everyone. V8 stated this past Saturday R2 hit V8 in the face while attempting to change R2's incontinence brief. V8 stated R2 calmed down once R2 allowed the staff to change R2, and believes the incontinence is what triggered R2's behavior. On 4/14/25 at 11:33 AM V3 Care Plan Coordinator stated R2 cusses, is resistive to staff, and has dementia. At 12:13 PM V3 stated R2's care plan includes R2 has the potential to be aggressive. V3 confirmed this care plan has not been updated with R2's physical altercation or new interventions to address this behavior. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at 9:37 AM V24 LPN stated R2 was in the hallway with V4 CNA when R2 fell on [DATE]. V24 stated V24 did not witness the fall and described R2 as being at her baseline, cursing and combative with staff when attempting to redirect or provide cares. V24 stated R2 just gets more agitated so we just try to reapproach R2 later. V24 stated staff had not mentioned if R2 was resistive or agitated prior to R2's fall. On 4/14/25 at 12:10 PM V2 Director of Nursing reviewed R2's behavior tracking report. V2 stated this is the behavior tracking that is used and is the same for all residents. V2 confirmed this behavior tracking does not identify R2's specific behaviors or personalized nonpharmacological interventions or approaches. V2 stated the nurses also document behaviors on the Medication Administration Record, but R2's specific targeted behaviors are not identified. On 4/15/25 at 10:40 AM V2 stated staff have been instructed when residents are resistive to cares they should try a different approach or try another staff person. V2 confirmed allowing time to vent and reapproach later would also be an appropriate intervention. V2 stated staff should honor the resident's right to refuse care and R2 does better for male staff. V2 confirmed V25 worked on 3/26/25 and confirmed staff should have implemented interventions or alternative approaches during R2's staff assisted fall. V2 confirmed pulling R2's wheelchair backwards would not be considered an acceptable approach. At 11:33 AM V2 confirmed R2's care plan has not been updated to include resistive to cares and nonpharmacological interventions/approaches to address this behavior.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 40385 Based on observation, interview, and record review the facility failed to follow physician's orders and manufacturer's instructions for two (R9, R11) of nine residents reviewed for medication administration in the sample list of 14. This failure resulted in three medication errors out of 26 opportunities, an 11.5% medication error rate. Findings include: 1.) R9's April 2025 Medication Administration Record (MAR) documents to administer Albuterol Sulfate Hydrofluoroalkane Inhalation Aerosol Solution 108 (90 Base) micrograms (mcg) per actuation give two puffs orally twice daily. On 4/14/25 at 3:27 PM V17 Licensed Practical Nurse administered two puffs of Albuterol 108 mcg inhaler to R9. The inhaler box had a label to shake, and V17 did not shake the inhaler prior to administration. At 3:50 PM V17 confirmed R9's Albuterol inhaler box contained a label to shake and confirmed she did not shake the inhaler prior to administration. V17 stated V17 was not aware V17 needed to shake the inhaler prior to administration. The Highlights of Prescribing Information for Albuterol Sulfate 108 mcg dated February 2019 documents to shake the inhaler well prior to each spray. 2.) R11's April 2025 MAR documents to administer Clonidine Hydrochloride 0.1 milligrams (mg) one tablet by mouth twice daily and hold if systolic blood pressure (SBP) less than 120. This MAR documents to give Insulin Lispro Injection Solution 100 UNIT per milliliter per sliding scale based on blood glucose four times daily at 7:00 AM, 11:00 AM, 3:00 PM, and 7:00 PM. R11's active vital sign report documents the last recorded blood pressure was 140/62 on 4/14/25 at 9:43 AM. On 4/14/25 between 3:38 PM and 3:48 PM V17 administered Clonidine 0.1 mg one tablet to R11. The medication card contained a label to hold the medication if R11's SBP was less than 120. V17 did not obtain R11's blood pressure prior to administering Clonidine. V17 checked R11's blood glucose level, which was 270 mg per deciliter. At 3:48 PM V17 administered Insulin Lispro 6 units, as ordered, into R11's right upper arm. There was no food at R11's bedside. On 4/14/25 at 3:42 PM R11 stated staff have not checked R11's blood pressure and R11 thought it was suppose to be checked twice daily. On 4/14/25 at 3:50 PM V17 confirmed R11's Clonidine physician order and medication card both document to hold for SBP less than 120. V17 stated R11's blood pressure was last checked that morning and V17 should have checked R11's blood pressure prior to administering Clonidine. At 4:48 PM V17 stated V17 thought short acting insulin could be given within 45 minutes of a meal. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/14/25 at 4:50 PM R11 was in R11's room. V26 Certified Nursing Assistant was pushing a cart of meal trays down R11's hallway. V26 stated hall trays, including R11's meal tray, had not been delivered yet. On 4/15/25 at 5:50 AM V2 Director of Nursing stated short acting insulin should be given within 15 minutes of a meal. The Highlights of Prescribing Information for Insulin Lispro dated September 2023 documents Lispro is a rapid acting insulin that should be administered within 15 minutes prior to a meal or immediately after a meal. The facility's Administering Medications policy dated April 2019 documents medications are administered according to physician orders.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 52228 Based on observation, interview, and record the facility failed to ensure a wheelchair was in safe operating condition for one (R3) of three residents reviewed for falls on the sample list of 14. Findings include: R3's Nursing Note dated 4/1/25 at 8:38 AM R3 had a witnessed fall. R3 was on the floor by his chair with his legs extended out in front of him and the Certified Nursing Assistant (CNA) stated R3 unclamped the sling from the lift and was then lowered to floor without hitting his head. At 12:20PM on 4/14/2025 V6 CNA stated when V6 lowered R3 into his reclining chair, the wheelchair was broken and tilted forward, causing R3 to slide out of the wheelchair. V6 stated R3's wheelchair had been broken for awhile prior to this fall. On 4/15/2025 at 1:30PM V9 CNA stated that she switched out R3's chair on 4/2/2025 due to the wheelchair being broken and tilted in an upright position. V9 stated she felt that R3 couldn't be comfortable sitting in the forward tilted position of the broken wheelchair. V9 stated R3's reclining wheelchair had been broken for awhile. On 4/15/2025 at 140PM, V11 (Maintenance Director) stated that the facility uses a logbook that he checks every 30 minutes to see if there are any repairs that need to be completed by the facility. V11 was observed going through the log and no date was given for R3's broken chair. V11 stated V11 was never notified that R3's reclining wheelchair was broken. Policy Dated April 2010 documents Maintenance work orders shall be completed in order to establish a priotrity of maintenance service which incudes work orers must be filled out and forwarded to the maintenance director. This documents also states that work orer requests should be placed in the Work Order Binder and are to picked up daily and emergency requests will be given priority in making necessary repairs.