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	04/23/2025

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 - Minimal harm or potential for actual harm Residents Affected - Some	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** 42702 Based on observation, interview, and record review the facility failed to ensure the right to be free from physical abuse for three (R1, R2, &R3) of four residents reviewed for abuse from a sample list of four residents. Findings include: 1.) The facility provided incident report dated 4/19/25 documents that an altercation between R1 and R3 occurred in the dining room at approximately 6:00 AM. V14, Dietary Aid's, written statement dated 4/19/25 documents that V14, Dietary Aid, heard R1 and R3 screaming in the dining room at approximately 6:00 AM. R3 had blocked R1 in the dining room and was cursing at her. R1 complained that R3 kicked her. R1's Minimum Data Set, dated dated dated dated 3/26/25 documents that R1 is cognitively intact. On 4/21/25 at 11:45 AM, R1 stated that R3 bothers her and that R3 hit her left knee a few days ago and caused her pain. On 4/21/25 at 12:00 PM, V3, R1's Family Member, stated that the facility notified her on 4/19/25 that R3 had hit R1's leg and that R1 confirmed that R3 had kicked her in the knee. 2.) The facility provided incident report dated 4/19/25 documents that at approximately 6:30 PM, R2 and R3 approached the exit door on the B hall and R3 pushed R2, resulting in a right knee skin tear. V7, Certified Nursing Assistant (CNA), stated that he observed R3 raise both hands, place them on R2's back and pushed R2 to the ground. R2's minimum data set documents that R2 is severely cognitively impaired. R2's progress notes dated 4/19/25 documents that V7, CNA, observed R3 push R2 to the floor. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/23/25 at 11:01 AM, V12(Licensed Practical Nurse (LPN)) removed R2's right knee dressing where a quarter-sized skin tear was observed. R2 winced in pain as V12 (LPN) moved R2's over the wound and above the knee. On 4/23/25 at 11:05 AM, R2 stated as the bandage was removed, That's my knee that hurts. 3.) R3's care plan dated 2/7/25 documents that R3 has the potential to be physically aggressive toward other residents. R3's Minimum Data Set, dated dated dated [DATE] documents R3 as severely cognitively impaired. R3's progress notes dated 2/9/25 documents that R3 has been very aggressive toward residents and staff with attempts at re-direction unsuccessful. R3's progress notes dated 4/19/25 documents that R3 was removed from the dining room at 6:30 AM while screaming. R3's progress notes dated 4/19/25 documents at 6:30PM that R3 was sitting in her wheel chair and that she and R2 were nearing the exit door on hall B when V4 (CNA) observed R3 push R2 with both hands causing R2 to fall. R3's 4/14/25 psychiatry note documents an increase in aggressive behavior. On 4/21/25 at 1:40 PM, V6 (Licensed Practical Nurse (LPN)) stated that R3 is aggressive toward both residents and staff. I was the evening nurse on 4/19/25 and after R3 pushed R2 onto the floor, we were instructed to send R3 to the emergency room because there had been two incidents with R3 in one day. On 4/21/25 at 1:57 PM, V9 (CNA) stated that when she came into work on 4/19/25, R1 and R3 were already arguing. R3 is hard to deal with. She uses a wheel chair and sometimes pushes it while walking. She curses at both residents and staff and she can also be physically aggressive. R3's local hospital notes dated 4/19/25 document that R3 was evaluated by the emergency room due to aggressive behavior with residents and staff. Out patient psychiatry was recommended. On 4/23/25 at 9:15 AM, V1 Administrator stated that R3 is transferring to a memory care unit to better meet her needs.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42702 Based on interview and record review the facility failed to implement effective interventions to prevent abuse for three (R1, R2, R3) of four residents reviewed for abuse from a total sample list of four residents. Findings include: The facility provided Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating Policy dated September 2022 documents that upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions are needed for the protection of residents. 1.) The facility provided incident report dated 4/19/25 documents that an altercation between R1 and R3 occurred in the dining room at approximately 6:00 AM. V14 Dietary Aid's written statement dated 4/19/25 documents that V14 Dietary Aid heard R1 and R3 screaming in the dining room at approximately 6:00 AM. R3 had blocked R1 in the dining room and was cursing at her. R1 complained that R3 kicked her. On 4/21/25 at 11:45 AM, R1 stated that R3 bothers her and that R3 hit her left knee a few days ago and caused her pain. R1's Minimum Data Set, dated dated dated dated 3/26/25 documents that R1 is cognitively intact. On 4/21/25 at 12:00 PM, V3, R1's Family Member, stated that the facility notified her on 4/19/25 that R3 had hit R1's leg and that R1 confirmed that R3 had kicked her in the knee. 2.) The facility provided incident report dated 4/19/25 documents that at approximately 6:30 PM, R2 and R3 approached the exit door on the B hall and R3 pushed R2, resulting in a right knee skin tear. V7, Certified Nursing Assistant (CNA), stated that he observed R3 raise both hands, place them on R2's back and pushed R2 to the ground. R2's Minimum Data Set, dated dated dated [DATE] documents that R2 is severely cognitively impaired. R2's progress notes dated 4/19/25 documents that V7, CNA, observed R3 push R2 to the floor. On 4/21/25 at 1:40 PM, V6 (Licensed Practical Nurse (LPN)) stated that R3 is aggressive toward both residents and staff. I was the evening nurse on 4/19/25 and after R3 pushed R2 onto the floor, we were instructed to send R3 to the emergency room because there had been two incidents with R3 and other residents in one day. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/21/25 at 1:57 PM, V9 (CNA) stated that when she came into work on 4/19/25, R1 and R3 were already arguing. R3 is hard to deal with. She uses a wheel chair and sometimes pushes it while walking. She curses at both residents and staff and she can also be physically aggressive. 3.) R3's care plan dated 2/7/25 documents that R3 has the potential to be physically aggressive toward other residents with the documented plan for intervention to intervene as needed to protect the rights and safety of others. R3's Minimum Data Set, dated dated dated [DATE] documents R3 as severely cognitively impaired. R3's progress notes dated 2/9/25 documents that R3 has been very aggressive toward residents and staff with attempts at re-direction unsuccessful. R3's progress notes dated 4/19/25 documents that R3 was removed from the dining room at 6:30 AM while screaming. R3's local hospital notes dated 4/19/25 document that R3 was evaluated by the emergency room due to aggressive behavior with residents and staff. Out-patient psychiatry was recommended. R3's progress notes dated 4/19/25 documents at 6:30 PM that R3 was sitting in her wheel chair and that she and R2 were nearing the exit door on hall B when V4 (CNA) observed R3 push R2 with both hands causing R2 to fall. R3's behavior monitoring and interventions report dated 4/17/25, 4/19/25, 4/20/25, and 4/22/25 document physical and verbal abuse toward others with interventional success on only one date, 4/17/25. On 4/23/25 at 9:15 AM, V1 stated that interventions such as moving R3 to a different hall from R1 and 1:1 observations should have been attempted to decrease the incidences of resident altercations.