

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER LA Bella at Clifton		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on interview and record review the facility failed to ensure a Minimum Data Set (MDS) accurately assessed for wandering for one of three residents (R1) reviewed for elopement in the sample list of eight.</p> <p>Findings include:</p> <p>R1's MDS dated [DATE] documents R1 has severe cognitive impairment and did not wander during the look back period.</p> <p>R1's Behavior tracking dated 4/30/25-5/22/25 documents R1 exhibited wandering behavior on 5/2/25 and 5/3/25. R1's Nursing Note dated 5/1/2025 at 4:41 AM documents R1 went into another resident room, turned on the lights, and woke up the unidentified resident.</p> <p>On 5/22/25 at 3:25 PM V29 (MDS Coordinator) stated V14 (Social Services Director) completes the behavior section of the MDS. V29 confirmed V29 signs off on the MDS as being complete and accurate. V29 reviewed R1's MDS and behavior tracking and confirmed R1's MDS does not identify R1's wandering behavior that occurred during the seven day look back period. V29 stated V29 will have to review the number of days R1 wandered and submit a correction of R1's MDS. V29 stated when wandering is entered on the MDS, it prompts for additional questions to answer.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385</p> <p>Based on observation, interview, and record review the facility failed to ensure a severely cognitively impaired resident (R16) did not exit the facility unnoticed (elopement), failed to implement post fall interventions (R6), and failed to thoroughly investigate a fall/injury (R7). R1 is three of four residents reviewed for elopement, and R6 and R7 are two of three residents reviewed for falls in the sample list of eight.</p> <p>Findings include:</p> <p>1.) R1's Minimum Data Set (MDS) dated [DATE] documents R1 has severe cognitive impairment, R1 has hallucinations/delusions, R1 does not use any mobility devices, and R1 transfers/walks with supervision or touch assistance from staff.</p> <p>R1's Admission Social Service assessment dated [DATE] documents the following: R1 has the physical ability to leave the facility. R1 is not sufficiently alert, oriented and coherent enabling him/her to be considered for independent outside pass privileges with a physician's order and appropriate compliance with any behavior management program/system/interventions. R1 has a history of unauthorized departure from a health care setting and/or verbalizing a serious intent to leave the facility. R1 has been hanging around facility exits and/or stairways or wandering between floors. R1 has been engaging in theme behavior such as a belief of specific responsibilities in another area such as going to work, returning home to take care of children, going to church, preparing dinner, etcetera. R1 is easily agitated, and or disoriented or shows poor judgement, for example would not be able to care for herself outside of the facility. R1 observes environmental or time of year cues, such as staff preparing to leave or putting on coats or approaching holidays, that may indicate a risk for elopement and specific triggers or warning signs to monitor that could suggest increased elopement risk.</p> <p>R1's Behavior Tracking dated 4/30/25-5/22/25 documents R1 was anxious, pacing and wandering on 5/2/25 and 5/3/25.</p> <p>R1's Care Plan with initiated date of 5/1/25 and revised date 5/8/25 documents the following: R1 admitted to the facility on [DATE] and is an elopement risk/wanderer with history of attempts to leave the facility unattended. R1 calls for her mom and asks to go visit her mom because R1 believes her mom is sick. While admitted in the hospital, R1 left to go visit her mom without anyone being aware. R1 sees people in the parking lot and believes they are R1's family or friends. On 5/7/25 R1 walked out of an emergency exit door and Social Services Director will help R1 find something on television that R1 enjoys watching. On 5/7/25 R1 exited through a fire exit during the night. Interventions dated 5/1/25 included monitor R1 for tailgating behaviors when visitors are in the facility, provide direct staff supervision when attending an out-of-facility activity, refer to social services as needed, use discreet identifier so staff are aware of R1's elopement risk, check functioning of the audible alarm system regularly and as needed, offer calling R1's family/friend for reassurance when exit seeking, and use audible monitoring system to alert staff of exit seeking behavior. R1's interventions dated 5/8/25 include one to one monitoring, room change closer to the nurse's station and away from fire exits, and talking with R1's family about sending referrals to memory care units.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R1's Social Service Note dated 5/7/2025 at 11:16 AM documents R1's family was notified that R1 wandered out an exit door and R1's family was asked about R1's activity interests to help with R1's anxiety and expecting family.</p> <p>R1's Nursing Note dated 5/7/2025 at 6:45 PM documents the following: V22 Certified Nursing Assistant (CNA) stated V22 checked on R1 at 6:30 PM and R1 was in R1's room talking on the telephone. V19 CNA took an unidentified resident out for a smoking break between 6:30 PM and 7:00 PM. While V19 was sitting outside V19 noticed R1 was outside on the phone in the parking lot attempting to leave the facility. Staff assisted R1 back into the facility. R1 was assessed and had no signs of injury. R1's family was notified and enhanced supervision was initiated with 15-minute checks by staff.</p> <p>On 5/22/25 at 12:06 PM V16 CNA stated R1 is generally very confused and R1 wanders/exit seeks making it pretty rough to watch R1. V16 stated R1 got out of the facility around 6:30-7:00 PM about two weeks ago. V16 stated V16 did not observe R1 leave the facility that night. At 1:45 PM V16 stated the night R1 got out, V16 looked out a resident room window on B hall and saw R1 partway between the front parking lot and circle drive with staff. V19 stated V19 last saw R1 after dinner in R1's room around 6:00-6:30 PM. V19 stated R1 paces and wanders so it is hard telling which exit door R1 left from without having eyes on (R1) constantly.</p> <p>On 5/22/25 at 1:06 PM V22 CNA stated when R1 first admitted R1 did not try to leave the facility, but R1's family was here more during that time. V22 stated R1 then started looking for her family, mostly going to the front desk and front door. V22 stated there was only one time that R1 got out of the facility, V22 was working that day, and it was around 7-7:30 PM. V22 stated V22 did not see R1 leave the facility, V22 was R1's assigned CNA that night, V22 last saw R1 around 6:30 PM in R1's room and V22 thought R1's family had visited R1 earlier that day. V22 stated V22 was on B hall when V22 heard a door alarm sound.</p> <p>On 5/22/25 at 1:18 PM in regard to R1's elopement on 5/7/25, V19 CNA stated V19 went outside through the front door that evening, to take another resident outside for a smoke break. V19 stated there were no door alarms sounding at that time. V19 was outside for about 5-10 minutes and as V19 was returning to the facility, V19 saw R1 outside of the facility near the corner of the C Hall exit walking towards the front parking lot and road. V19 confirmed no staff was present with R1. V19 stated this incident occurred around 6:00-7:00 PM. V19 described R1 as being very confused that night and R1 did not want to go back into the facility. V19 stated V19 called V13 CNA to get help and notify the nurses. V19 stated at this time V2 Director of Nursing (DON) pulled into the parking lot, R1 was assisted back into the facility and placed on 15-minute checks. V19 stated prior to the incident V19 last saw R1 during dinner around 5:00 PM.</p> <p>On 5/22/25 at 2:24 PM V13 CNA stated V13 last saw R1 after dinner and received a phone call from V19 who found R1 outside of the facility.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/22/25 between 2:27 PM-2:34 PM V14 Social Services Director stated R1 was identified to be at risk for elopement and a departure alert device was initiated the day R1 admitted to the facility. V14 stated R1 wandered out of an exit door on 5/7/25 about 10:30-11:00 AM. V14 stated the C Hall door alarm sounded and either V2 DON or V5 Maintenance Director found R1 outside the facility. V14 stated this prompted V14 to notify R1's family to inquire about R1's activity interests, and R1's room was changed to closer to the nurse's station. V14 confirmed one to one monitoring was not implemented until after R1's elopement on the evening of 5/7/25. V14 stated R1's family had been visiting and taking R1 home which caused R1 increased confusion and anxiety. V14 stated R1 was always watching the parking lot and V14 knew then that R1 needed a memory care unit.</p> <p>On 5/22/25 at 2:06 PM V2 DON stated V14 is responsible for assessing elopement risk and R1's family reported R1 had a history of wandering. V2 stated I don't think we (the staff) were aware of how bad her (R1's) wandering actually was. V2 stated the departure alert bracelet was implemented initially and then we changed R1's room away from the exit doors, closer to the nurse's station to be within line of sight from the nurse's station. V2 stated we implemented a one to one sitter after R1's elopement incident on the evening of 5/7/25. V2 stated on 5/7/25 around 6:40 PM V2 pulled into the parking lot and the CNAs were already outside with R1 at that time. V2 stated V19 had been outside with another resident for a smoke break and V19 saw R1 as V19 was going to return back into the facility. V2 stated R1 was found in the vicinity of the outdoor benches located near the C Hall exit after the D Hall door alarm sounded, which alerted staff. V2 stated R1 was last observed at 6:30 PM in R1's room by V22, R1's assigned CNA that night. V2 stated that was the last time staff saw R1 prior to being found outside of the facility by V19.</p> <p>2.) R6's Nursing Note dated 5/13/2025 at 6:30 PM documents R6 was observed standing at the desk and then fell to the floor hitting R6's head. R6's eyes rolled back and R6 had body twitching lasting approximately three seconds. R6 vomited twice. R6's pulse was 158 beats per minute and blood pressure was 102/74 millimeters of mercury. R6 was transferred to the local hospital.</p> <p>R6's Care Plan dated as revised on 5/14/25 documents the following: R6 is at high risk for falls. On 4/7/25 R6 was found on the floor near the nurse's station and the root cause was R6 became dizzy and lost balance. On 3/1/25 R6 fell at the nurse's station and the root cause was hypotension. On 1/6/25 R6 had a staff assisted fall and the root cause was hypotension, vomiting and diaphoresis (clammy/sweaty). On 12/7/24 R6 had an unwitnessed fall in the dining room and root cause was R6 became dizzy and lost balance. Neurology referral is listed as an intervention dated 5/13/25.</p> <p>As of 5/22/25 there was no documentation in R6's medical record that a neurology appointment had been scheduled for R6.</p> <p>On 5/22/25 at 5:26 PM V9 Licensed Practical Nurse stated V9 was talking with R6 who was standing at the desk prior to R6's fall. V9 stated R6 seemed just fine prior to the fall, R6 then fell suddenly to the floor and vomited. V9 stated R6 has a history of these spells that come on suddenly and without warning. V9 stated V2 DON said cardiology and neurology consults were ordered.</p> <p>On 5/22/25 at 4:57 PM V2 DON stated R6 has a history of these spells and has been sent to the hospital following each of these spells/falls. V2 confirmed the facility had not yet attempted to schedule a neurology consult appointment for R6. V2 confirmed cardiology and neurology consults were the post fall interventions for R6's 5/13/25 fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3.) R7's MDS dated [DATE] documents R7 has severe cognitive impairment, uses a walker for mobility, and uses partial/moderate assistance from staff for toileting, transfers, and walking over 150 feet, and requires supervision or touch assistance with walking up to 50 feet.</p> <p>R7's Nursing Note dated 5/12/2025 at 2:44 PM documents R7 had a skin tear to the left elbow and swelling. R7 reported to V30 Business Office Manager that R7 fell out of bed. An x-ray of the left elbow was ordered due to swelling.</p> <p>R7's Practitioner Note dated 5/12/25 at 2:17 PM documents R7 reported left elbow pain that started today. R7 stated R7 fell out of bed and landed on his elbow and R7 was unsure if R7 fell today or yesterday. R7 was unable to give additional information due to dementia with intermittent confusion. R7 reported severe pain with palpation and redness was noted to left elbow. R7's Practitioner Note dated 5/14/25 at 1:12 PM documents R7's left elbow x-ray was completed on 5/12/25 due to fall with new swelling and pain. R7's x-ray showed soft tissue swelling, but no fracture.</p> <p>R7's Care Plan dated as revised 5/15/25 documents R7 is at high risk for falls related to confusion and deconditioning. This care plan includes an intervention dated 4/27/25 for prompted toileting program and intervention dated 5/12/25 for a scoop mattress to help R7 identify safety boundaries of the bed.</p> <p>On 5/22/25 the facility's investigative file of R7's 5/12/25 fall, provided by V2 DON, was reviewed and the file did not include any staff interviews or statements regarding R7's fall/left elbow injury.</p> <p>On 5/22/25 at 4:27 PM R7 was lying in bed and R7 had redness and mild swelling of the left elbow. R7 stated R7 fell out of bed recently. R7 was unable to give any additional information regarding this fall.</p> <p>On 5/22/25 at 4:57 PM V2 stated swelling was noticed on R7's elbow, R7 was asked what happened and R7 stated R7 had fallen out of bed. V2 stated R7 walks independently with a four wheeled walker and it would be possible for R7 to self transfer off of the floor if he had fallen. V2 stated V2 spoke with staff regarding R7's fall/injury, but V2 does not have documentation of this. V2 stated the day prior R7 did not have any elbow swelling and V2 was unable to identify when or if R7 had actually fallen. V2 confirmed R7 had a prior post fall intervention for prompted toileting and there was no documentation of when R7 was toileted the day of R7's reported fall and left elbow injury.</p> <p>The facility's Fall Risk Assessment policy dated March 2018 documents staff will evaluate for functional and psychological factors that may increase a resident's fall risk, staff will identify environmental factors that may contribute to falling., and the staff and physician will collaborate to identify and address modifiable fall risk factors and interventions to try to minimize the consequences.</p>		