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	05/06/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38780 Based on observation, interview, and record review, the facility failed to develop and implement a person-centered comprehensive care plan to include residents smoking status. This failure affects one (R16) of seven residents reviewed for accidents in the sample list of 33. Findings include: The facility Care Plans, Comprehensive Person-Centered Policy (reviewed December 2024) documents the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition. R16's Face Sheet dated 5/6/25 documents R16 was admitted to the facility on [DATE]. The facility Smoker List (undated) documents R16 is an independent smoker who requires supervision. R16's photo sheet that accompanies the Smoker List further documents R16 must wear a smoking apron. On 5/5/25 at 12:58pm, R16 observed out front of the facility smoking a cigarette and supervised by staff. On 5/6/25 at 1:15pm, R16 observed out front of the facility smoking a cigarette and supervised by staff. R16's Safe Smoking Evaluations dated 3/26/25 and 4/8/25 documents R16 is a safe smoker, requires no assistance to smoke, and develop care plan. R16's Care Plan dated 5/5/25 does not document R16 as being a smoker. (continued on next page)

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

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	05/06/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/6/25 at 11:18am, V1 Administrator stated R16 admitted to the facility as a non-smoker and began smoking a month later. V1 stated R16's Care Plan was updated today (5/6/25) to include smoking and interventions.

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	05/06/2025

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 41002 Based on observation, interview, and record review, the facility failed to employ a clinically qualified Director of Food and Nutrition Services. This failure has the potential to affect all 74 residents residing in the facility. Findings include: On 5/5/25 and 5/6/25 V7 Dietary Manager was actively supervising dietary operations in the facility kitchen during resident meal preparations. On 5/6/25 at 8:46am V7 Dietary Manager stated that V7 is the full-time manager of the facility food service and not being a clinically qualified Certified Dietary Manager or having the equivalent training. On 5/6/25 at 9:00am V1 Administrator confirmed that V7 Dietary Manager is the full-time Dietary Manager, and is not Certified as a Dietary Manager or have the equivalent training The Resident Census and Conditions of Residents report dated 5/4/25 documents 74 residents reside in the facility. Facility Assessment Tool dated 4/2025 documents: Facility Resources Needed to Provide Competent Support and Care for our resident Population Every Day and During Emergencies. Position Dietitian or other clinically qualified nutrition professional to serve as the director of food and nutrition services. Full Time Food Service Manager.