

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2025
NAME OF PROVIDER OR SUPPLIER  LA Bella of Rochelle		STREET ADDRESS, CITY, STATE, ZIP CODE  1021 Caron Road Rochelle, IL 61068	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on interview and record review the facility failed to ensure residents were allowed to smoke for 17 of 19 residents (R1 and R3-R18) reviewed for resident rights in the sample of 19.</p> <p>The findings include:</p> <p>On 6/17/25 the facility provided list of residents that smoke which included R1 and R3-R18.</p> <p>On 6/17/25 at 9:15 AM, R15 stated she was told by facility staff on Friday (6/13/25) that the 5:30 PM smoke break was going to be discontinued starting the following Monday (6/16/25). R15 said all the smokers were told on Friday but they would still have the weekend to get a 5:30 PM smoke break. R15 said none of the smokers got to go outside at 5:30 PM on Saturday because there was no one to take them outside.</p> <p>On 6/17/25 at 9:28 AM, R3 said over the weekend the 5:30 PM smoke break was taken away. R3 said she was seated outside on the patio on Saturday. It was after dinner and she was not allowed to smoke. R3 said she heard two male residents yelling just inside the door. It was something about not being able to smoke. R3 said she was told the 5:30 PM smoke break would continue over the weekend, but it did not.</p> <p>On 6/17/25 at 9:35 AM, R1 said he was arguing with staff over the weekend about a smoke break not happening. R1 said they were told the day before, the 5:30 PM break was going away but that they would still be allowed outside over the weekend. R1 said it wasn't supposed to happen for a few more days.</p> <p>On 6/17/25 at 3:39 PM, R8 stated he goes out to smoke at almost every break. R8 said he was told the 5:30 PM break was going to stop on a Monday. R8 said it stopped on the Saturday before then. R8 said the staff told them they still had the weekend to go outside to smoke at 5:30 PM, but that didn't happen.</p> <p>On 6/17/25 at 3:42 PM, R7 said the facility took away the 5:30 PM smoke break over the weekend. R7 said it wasn't supposed to happen until Monday, but they did it anyway.</p> <p>(continued on next page)</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2025
NAME OF PROVIDER OR SUPPLIER  LA Bella of Rochelle		STREET ADDRESS, CITY, STATE, ZIP CODE  1021 Caron Road Rochelle, IL 61068	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/17/25 at 8:52 AM, V10 (Certified Nurse Aide) stated she heard there was an incident on Saturday (6/14/25). It was around 5:30 PM. The residents were upset because they weren't getting their 5:30 PM smoke break. They had been told on Thursday and Friday that the 5:30 PM smoke break was going to be stopped. The activity aide who was the person who had been supervising that smoke break was not available on Saturday. V10 said she thought it was supposed to start on Saturday but found out later it was not supposed to start until Monday.</p> <p>On 6/17/25 at 2:16 PM, V4 (Registered Nurse) stated R1 was yelling and screaming on Saturday because he wasn't allowed to go outside for the after-dinner smoke break. V4 said none of the smokers were allowed to smoke that evening.</p> <p>On 6/17/25 at 2:59 PM, V8 (Activity Director) said residents were given a one week notice that the 5:30 PM smoke break was going to be discontinued. It was supposed to start yesterday (6/16/25) due to lack of staff to supervise. Residents got verbal alerts and they had to sign a paper showing they knew of the upcoming change. V8 said there wasn't enough staff to supervise them over the weekend so the 5:30 PM smoke break did not happen.</p> <p>On 6/17/25 at 3:04 PM, V2 (Director of Nurses) said the 5:30 PM smoke break was discontinued due to lack of staff supervision. The activity department usually supervises and they are leaving the building at an earlier time now. V2 said the administrator had meetings with each smoker and they signed forms on Friday (6/13/25). The change should not have taken effect until Monday (6/16/25).</p> <p>On 6/17/25 the facility provided a list of the residents that smoke. The list included R1 and R3-R18. The document showed the smoking times of 9 AM, 11 AM, 1 PM, 4 PM and 530 PM. The 530 PM time was crossed off with a black pen. The facility supplied documentation of the residents' in-services regarding smoke breaks. The in-service showed new smoking times (without the 530 PM time) and a start date of Monday, 6/16/25.</p> <p>The facility's Resident Smoking Privileges policy revision dated 11/2024 states: 8. Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting) at designated times, and in accordance with his/her care plan.</p> <p>The facility's Residents' Rights policy (undated) states under the rights to dignity and respect section: Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2025
NAME OF PROVIDER OR SUPPLIER  LA Bella of Rochelle		STREET ADDRESS, CITY, STATE, ZIP CODE  1021 Caron Road Rochelle, IL 61068	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a residents (R1 &amp; R2) were free from physical abuse for two residents reviewed for abuse in the sample of 19.</p> <p>The findings include:</p> <p>On 6/17/2025 at 9:17 AM, R2 was sitting in the activity/sitting area watching television. R2 did not understand this surveyor's questions due to R2 mostly speaking Spanish. V11 (Certified Nursing Assistant-CNA) translated for this surveyor and R2. R2 was asked about the incident with another male resident a few days prior. R2 said R1 was walking from the back hall. R2 said he (R2) got up to go over to the table across the room. R1 pointed to him to go over there, (like get moving), then R1 hit him (R2) in the shoulder and made him hit his head on the wall. R2 said they sent him to the hospital to check him out. He does not think he had any injuries. R2 said R1 hit him at least 3 times. R2 pointed to each area his left lower arm, upper left arm, and his right shoulder. R2 said he swung back at R1, but R1 was the one that started it. R2 said he feels safe in the facility; but if R1 does try to hit him again, he will fight back. R2 was asked if he had any problems with R1 prior to that incident. R2 said sometimes when he (R1) is sitting in the TV room, R1 would come and talk to him. R2 said it triggers him (R2), because R1 will call him (A wrong name). R2 said when that happens, he (R2) would just get up and go to his room. R2 said he has not had any problems with R1 after the incident. No visible signs of injury were observed on R2.</p> <p>On 6/17/2025 at 9:35 AM, R1 was in his room exiting the bathroom. R1 was asked about the physical altercation with another resident a few days prior. R1 stated, the guy was taunting me, I was like what does he want. R1 said he (R2) was grunting, so I asked if he wanted to fight or what. R1 said he (R2) got up and threw his walker towards me, I stood up and hit him. I was protecting myself. R1 said the nurse, or a CNA stepped in, and he accidentally hit her because he blanked out. R1 said before it happened, I was arguing with staff about the smoke break. I said we should get a smoke break because we were just told about the change in smoke break times, and it was not supposed to happen until a few days later. R1 said he has not gotten into any arguments or physical altercations with R2, other residents, or staff prior to the incident. R1 said it was an accident that he hit the staff. It was not an accident that I hit the other resident. R1 said he does not know his name (R2's). R1 said he had not had any problems with that resident before or after. R1 said he tries to harass me every now and then, by grunting at me, but I just ignore him and walk. I feel safe in the facility. I went to the hospital that night for hip pain, due to his walker hitting my left side or my kidney or something. I came back that night. No visible signs of injury were observed on R1.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2025
NAME OF PROVIDER OR SUPPLIER  LA Bella of Rochelle		STREET ADDRESS, CITY, STATE, ZIP CODE  1021 Caron Road Rochelle, IL 61068	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/17/2025 at 12:45 PM, V5 (Certified Nursing Assistant-CNA) said she worked 6:00 PM-6:00 AM shift on 6/14/2025. V5 said staff were doing rounds for the residents. R1 kept yelling that he wanted to smoke and was hitting the walls down the hallway, in his room. R2 was sitting in the TV/Activity room in a chair. R1 kept walking to the nurse's desk yelling, We can smoke, it wasn't supposed to happen until Monday. R1 kept yelling. He went to the dining room/activity room with the television and started hitting the table chanting, We want to smoke. He came out of there and went to his room, hit the door, and was slamming things. R1 came back out of his room. V5 said she went down the hall to answer a resident's call light. As I came back out, I heard V4 (Registered Nurse/RN) yelling. R1 was standing over R2. R2 told him to be quiet. R1 hit R2 in the head. R2 stood up and hit R1 back. R1 hit R2 a couple times. V4 got in between R1 and R2. R1 still proceeded to hit R1 multiple times. R2 lost his balance and started falling. V5 said she and V4 caught R2 before he fell. V5 said R1 ran back to his room and stayed in his room until the police arrived. V5 said R1 has some behaviors at night, but not to the extent that he was ever aggressive towards other residents. V5 said he has yelled at staff. V5 said she was not aware of R1 swinging at any staff, or anything physical like that.</p> <p>On 6/17/2025 at 1:35 PM, V6 (CNA) said she saw the altercation. V6 said I was walking back from a resident's room and saw the nurse running to stop the fight. R2 was sitting down watching television, and R1 was behind the couches by the smoking door. R1 hit R2 in the head because R2 told him to be quiet. V6 said that is why R1 got mad and hit R2. V6 said R1 was hitting R2 in the face, and R2 was defending himself. I did not see it start. V6 said V12 (CNA) called 911. V6 said V4 split the residents up. V6 said it happened quick. It was kind of difficult to separate them, because they were going at it. V6 said V5 (CNA) was there too. V6 said she has not seen R1 hit another resident prior to that incident, adding that she was a new hire. V6 said R1 went to his room and R2 sat back down in the chair. V6 said she did not see any bleeding or bruising on either resident before they were sent out to the local hospital, or after they came back to the facility that night.</p> <p>On 6/17/2025 at 2:16 PM, V4 (RN) said on Saturday 6/14/2025. R2 was not the aggressor. He was very calm. V4 said R1 was very agitated. yelling, screaming, going back and forth from his room. V4 said she let R1 know that smoking hours were over and would resume the next morning. V4 said R1 was screaming profanities and punching and kicking the door and the wall in his room. V4 said R1 went to the TV area and was yelling anarchy, anarchy. V4 said R2 told R1 to please be quiet. V4 said she was trying to put stuff away quickly in the medication cart, lock it and make her way to the sitting area. V4 said she saw R1 hit R2. R2 got up and hit R1. V4 said she went over and separated them both. Staff were calling 911 while I was trying to break the fight up. V4 said she got elbowed in the shoulder by R1 while trying to break up the fight. V4 said she assessed both R1 and R2, and did not see any injuries on either resident. V4 said the paramedics assessed both residents. V4 said R2 was sent out to make sure there were no injuries. R1 was sent out due to aggressive behaviors. V4 said she was still on duty after they both came back and neither of them had any injuries. No new orders were given by the local hospital's emergency department doctor. Just to follow up with their doctor. V4 said R1 has been sent out to the local hospital before due to an incident involving behaviors with staff. Nothing physical. V4 said R2 has not had any aggressive behaviors that she is aware of, adding he is usually pretty quiet.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2025
NAME OF PROVIDER OR SUPPLIER  LA Bella of Rochelle		STREET ADDRESS, CITY, STATE, ZIP CODE  1021 Caron Road Rochelle, IL 61068	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/17/2025 at 10:07 AM, V2 (Director of Nursing-DON) said she was at home when V10 (CNA) called her at 6:59 PM about the incident. V2 said she told her she was on her way. V2 said V4 called her around 7:32 PM to tell her there were residents in here being aggressive and fighting. V2 said V4 told her the police and emergency medical services had been called. V2 said she called V3 (Social Services Director-SSD) because she lived close to the facility and V3 told her she was already at the facility. V2 said V3 told her the police were already at the facility. V2 said when she arrived at the facility, V3 told her what happened. The nurse (V4) told V3 that R1 and R2 just started fighting and she tried to get in between them. she (V4) told staff to call 911. V2 said the police came and took both residents out of the facility. V2 said V4 said R1 was agitated earlier due to the facility taking away the last smoke break. He was punching the air, called her a racial slur, and refused to take his medications. V2 said she asked R1 what started the fight. He said that guy is an agitator, what he says and what he does. He agitates him and another resident. V2 said on 6/16/2025 she did see when R1 walked by R2, he (R2) did make a grunting/growling noise. V2 said when R1 first came back to the facility on 6/14/2025 he was on 1:1 supervision, then it was changed to 15-minute checks. V2 said the psychiatric Nurse Practitioner was notified of the incident, and an order for as needed Haldol was given because the hospital did not make any medication changes prior to sending him back to the facility on 6/14/2025. V2 said when R2 came back to the facility on 6/14/2025 he denied pain. V2 said R1 and R2 were kept separated after they returned to the facility on 6/14/2025.</p> <p>The facility's Incident Investigation dated 6/15/2025 showed R1 was the aggressor and hit R2. The investigation showed R1 had been very agitated due to missing a smoke break and was yelling, swearing, and punching the walls in his room and slamming doors. The investigation showed R1 observed having an altercation with another resident and punched the other resident several times. The investigation showed R1 also received punches from the other resident. 911 was called and staff were able to successfully break up the altercation. R1 taken to the hospital for evaluation.</p> <p>R1 and R2's background checks were reviewed. Both R1 and R2 had a hit on their background checks. R1 for property damage and domestic battery, and R2 for battery. The background checks showed R1 was listed as moderate risk. Requires closer supervision and more frequent observation than standard or routine. Should ascertain whether the level of supervision is sufficient. R2 was listed as a low risk. R1 and R2's care plans were reviewed showing interventions for behavior/aggression were in place. The 6/14/2025 local Police report was reviewed.</p> <p>The facility's one-on-one supervision and 15-minute checks were reviewed with no concerns.</p> <p>R1's 6/14/2025 After Visit Summary from the local hospital was reviewed showing the reason for R1's hospital visit was Behavioral Problem. R2's 6/14/2025 After Visit Summary from the local hospital showed Assault. Contusion of head.</p> <p>R1's progress notes for the last three months showed increased agitation towards V1 (Administrator) on 3/21/2025. Sent to a local hospital for evaluation.</p> <p>R1's admission Record, provided by the facility on 6/17/2025 showed he had diagnoses including, but not limited to, schizoaffective disorder, restlessness and agitation, and generalized anxiety disorder. R2's admission Record, provided by the facility on 6/17/2025 showed diagnoses including, but not limited to, paranoid schizophrenia, dementia, adjustment disorder with mixed anxiety and depressed mood, and shizoaffective disorder-bipolar type.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  146152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/20/2025
NAME OF PROVIDER OR SUPPLIER  LA Bella of Rochelle		STREET ADDRESS, CITY, STATE, ZIP CODE  1021 Caron Road Rochelle, IL 61068	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy and procedure titled Abuse, Neglect and Exploitation, with a revision date of 11/2024, showed Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations .Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking .</p>		