STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146152	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Bella of Rochelle	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)
F 0600 Level of Harm - Minimal harm or potential for 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. (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
	146152	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Bella of Rochelle	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to prevent abuse between two residents when R1 hit R2, This failure applies to two of four residents (R1/R2) reviewed for abuse in the sample of six.The findings include:The written Statement from Administrator dated 10/20/25 in an investigation file for R1 & R2 showed, On October 20th, during a conference call around noon, the writer was informed of a confrontation between two residents, R2 and R1 both with a BIMS (Brief Interview of Mental Status) of 15 (no cognitive impairment). R2 reported that she entered R1's room without a clear reason, which R1 found objectionable. Following this, R1 confronted R2 in her own room. R1 claimed that R2 was going through her personal belongings, which she did not appreciate. At the time of these interviews, there was no evidence or confirmation of physical contact or altercation between the two. The Medical Doctor was notified, and the Power of Attorney (POA) was contacted. A preliminary investigation was initiated, although initially, there was no founded evidence of an altercation, and thus, it was not reported externally. The facility did not have an Initial Report for the resident-to-resident altercation between R1 and R2.On 10/23/25 at 8:34 AM, V3 Registered Nurse (RN) stated on Monday (10/20/25) she was working and R1 and R2 had an altercation. V3 stated she wasn't the nurse for R1 and R2; V4 RN was working in that area. V3 stated she was told R2 was caught in R1's room going through R1's things. Someone told R1 that R2 went into R1's room. R1 and R2' share a bathroom in between their room. R1 went to her room, went through the bathroom to R2's room and punched her in the face. This has not happened before; neither resident have been physical before with each other. V3 stated when something like this happens the nurse will assess the residents, let management know what happened, and they do the investigation and reporting. In the past the police would be called when something like this happens, but she did not see the police come in this time. V3 stated the Administrator, Director of Nursing (DON), and Social Services were here when this happened.On 10/23/24 at 8:40 AM, V5 Certified Nursing Assistant (CNA) stated he was working at the time of the incident between R1 and R2. V5 stated he was in the hall going to get a dressing for V4 RN who was in a room doing a dressing change. V5 stated when he came back with the dressing, V4 told him to get V2 DON because R1 had punched R2. V5 stated he went and got V2 and V2 got V1 Administrator. R2 did not go to the hospital. V5 stated he did not see any injury to R2's face. V5 stated the police did not come in for the incident. V5 stated he has never had a problem between R1 and R2 before. V5 stated R1 doesn't have any behaviors and has never hit any residents before. V5 stated R2 has behaviors of going into other residents' rooms and taking things that are not hers. V5 stated they try to monitor R2 as much as they can, so this doesn't happen. V5 stated when R2 goes into someone else's room V2 will talk to her about having personal boundaries and tell her she can't take other residents things. V5 stated this gets documented, grievances are filled out, and V1 is notified.On 10/23/24 at 8:45 AM, R1 was sitting in a wheelchair by the door in the common area waiting to go outside to smoke. R1 declined going anywhere to talk in private and stated it could be done right there. R1 stated on Monday R2 was in her room stealing. R1 stated R2 was bent over a box container that had snacks in it under her bed. R1 stated R2 ran from R1's room through the bathroom and jumped onto R2's bed. R1 stated she followed R2 into her room and she punched R2 in the face. R1 stated R2 has stolen stuff from her room before and no one is doing anything about it, R1 stated she took things into her own hands and hit R2 in the nose. R1 stated R2 stays away from her now. R1 stated they offered to give her a different room and she doesn't want to change rooms. R1 stated she keeps the bathroom door to her room closed at all times now. R1 stated if they (facility) would do something about R2 stealing then this would not have happened. R1 stated if the facility would have handled R2 stealing before this then she would not have had to. R1 stated she was told she can't hit people yet staff were glad that she did it because R2 steals from them and other residents. R1 stated she does not go around hitting people and knows not to do that.On 10/23/25 at 8:56 AM, R2 was in her room, awake, laying on her bed. R2 stated she got in a fight because R1 was mad at her. R2 stated she went into R1's room and was going through her stuff to find something to drink. R2 stated snack time was 4 hours away and she wanted something now. R2 stated R1 did not tell her she could go in her room or through her stuff. R2 stated she knows it was wrong. R2 stated she was in R1's room and the janitor saw her. R2 stated when R1 came back to her room she came over to R2's room and punched her in the face. R2 stated she did not get hurt, and she was not upset over being hit. R2 denied any injury. R2 stated she is not afraid of R1 and did not want to change rooms. R2 stated after it happened V1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146152	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Bella of Rochelle	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)
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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146152	A. Building B. Wing	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Bella of Rochelle	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an allegation of abuse between two residents to the state agency when R1 hit R2. This failure affects two of four residents (R1/R2)reviewed for abuse in the sample of six.The findings include:The written Statement from Administrator dated 10/20/25 in an investigation file for R1 & R2 showed, On October 20th, during a conference call around noon, the writer was informed of a confrontation between two residents, R2 and R1 both with a BIMS (Brief Interview of Mental Status) of 15 (no cognitive impairment). R2 reported that she entered R1's room without a clear reason, which R1 found objectionable. Following this, R1 confronted R2 in her own room. R1 claimed that R2 was going through her personal belongings, which did she did not appreciate. At the time of these interviews, there was no evidence or confirmation of physical contact or altercation between the two. The Medical Doctor was notified, and the Power of Attorney (POA) was contacted. A preliminary investigation was initiated, although initially, there was no founded evidence of an altercation, and thus, it was not reported externally. The facility did not have an Initial Report for the resident-to-resident altercation between R1 and R2.On 10/23/25 at 8:34 AM, V3 Registered Nurse (RN) stated on Monday (10/20/25) she was working and R1 and R2 had an altercation. V3 stated she wasn't the nurse for R1 and R2; V4 RN was working in that area. V3 stated she was told R2 was caught in R1's room going through R1's things. Someone told R1 that R2 went into R1's room. R1 and R2' share a bathroom in between their room. R1 went to her room, went through the bathroom to R2's room and punched her in the face. R2 did not go to the hospital. R1 and R2 were separated for the day and monitored. V3 stated when something like this happens the nurse will assess the residents, let management know what happened, and they do the investigation and reporting. In the past the police would be called when something like this happens, but she did not see the police come in this time. On 10/23/24 at 8:40 AM, V5 Certified Nursing Assistant (CNA) stated he was working at the time of the incident between R1 and R2. V5 stated he was in the hall going to get a dressing for V4 RN who was in a room doing a dressing change. V5 stated when he came back with the dressing, V4 told him to get V2 DON because R1 had punched R2. V5 stated the police did not come in for the incident. V5 stated he has never had a problem between R1 and R2 before. V5 stated R1 doesn't have any behaviors and has never hit any residents before. V5 stated R2 has behaviors of going into other residents' rooms and taking things that are not hers. On 10/23/24 at 8:45 AM, R1 was sitting in a wheelchair by the door in the common area waiting to go outside to smoke. R1 declined going anywhere to talk in private and stated it could be done right there. R1 stated on Monday R1 was in her room stealing. R1 stated R2 was bent over a box container that had snacks in it that had been under her bed. R1 stated R1 ran from R2's room through the bathroom and jumped onto R2's bed. R1 stated she followed R2 into her room and she punched R2 in the face. R1 stated R2 has stolen stuff from her room before and no one is doing anything about it, R1 stated she took things into her own hands and hit R2 in the nose. R1 stated R2 stays away from her now. R1 stated they offered to give her a different room and she doesn't want to change rooms. R1 stated she keeps the bathroom door to her room closed at all times now. R1 stated if they (facility) would do something about R2 stealing then this would not have happened. R1 stated if the facility would have handled R2 stealing before this then she would not have had to. R1 stated she was told she can't hit people yet staff were glad that she did it because R2 steals from them and other residents. R1 stated she does not go around hitting people and knows not to do that.On 10/23/25 at 8:56 AM, R2 was in her room, awake, laying on her bed. R2 stated she got in a fight because R1 was mad at her. R2 stated she went into R1's room and was going through her stuff to find something to drink. R2 stated snack time was 4 hours away and she wanted something now. R2 stated R1 did not tell her she could go in her room or through her stuff. R2 stated she knows it was wrong. R2 stated she was in R1's room and the janitor saw her. R2 stated when R1 came back to her room she came over to R2's room and punched her in the face. R2 stated she did not get hurt, and she was not upset over being hit. R2 denied any injury. R2 stated she is not afraid of R1 and did not want to change rooms. R2 stated after it happened V1 Administrator, and V2 DON came and talked to her, and she told them what happened. V1 and V2 told her not to do it again. R2 stated the police did not come in and talk to her. R2 stated she doesn't go into other people's room all the time. R2 stated she just so hungry that she wasn't thinking straight and was trying to find something to eat and drink.On 10/23/25 at 9:51 AM, V1 Administrator stated they did not report the incident between R1 and R2 to Illinois Department of Public Health (IDPH) because we wanted to do a