| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146152 | A. Building<br>B. Wing | 12/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LA Bella of Rochelle | 1021 Caron Road<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>(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 |
|---|---|---|
| | | |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the safety of residents by allowing a nurse with witnessed behavior changes outside her norm to provide cares to residents. This failure had the potential to affect all 25 residents (R1-R25) V12 Licensed Practical Nurse (LPN) cared for on 12/2/25. The findings include:The facility's December 2025 nursing schedule showed V12 LPN worked in the facility from 6AM-6PM on 12/2/25. The schedule showed V3 Certified Nursing Assistant (CNA), V4 CNA, V9 Housekeeping, V10 Dietary Manager, and V11 CNA worked with V12 LPN on 12/2/25. A facility resident roster printed 12/4/25 showed V12 LPN was assigned to and provided cares to R1-R25 on 12/2/25.On 12/5/25 at 7:51 AM, V3 CNA stated on 12/2/25, V3 observed V12 LPN falling asleep standing up. She would sit down and nod off. Just bizarre and scary behavior. V3 stated she also observed V12 LPN drawing up a medication in a syringe but her eyes kept closing and she would nod off. V3 CNA stated she reported V12 LPN behaviors to V1 Administrator and V2 Director of Nursing (DON) the morning of 12/2/25. V3 stated, (V1 Administrator) kept telling me to keep an eye on her. I don't know what happened after that but (V12 LPN) did work her full shift that day.On 12/5/25 at 8:20 AM, V4 CNA stated on 12/2/25, V4 observed V12 LPN falling asleep while working. V4 stated, (V12) was falling asleep standing up at the med cart. She would lean forward on the cart with her eyes closed. At some point, I saw her drawing up a medication with her eyes closing off and on. I also saw her testing (R2's) blood sugar. (R2) was sitting down and (V12) was bent over, with her eyes closed, next to (R2), while waiting for the blood sugar results. V4 CNA stated she reported V12 LPN's behaviors to V1 Administrator on the morning of 12/2/25. V4 stated V1 Administrator told V4 to keep an eye on V12. V4 stated, I don't know what happened with (V12) but she was a huge safety issue. She was still working the floor when I left that day. On 12/5/25 at 9:58 AM, V9 Housekeeping stated on 12/2/25, she observed V12 LPN standing at her med cart, trying to punch out pills in a cup but she would nod off, her head would jerk back, and she would wake up. V9 stated she reported V12's behaviors to V1 Administrator on 12/2/25.On 12/5/25 at 10:10 AM, V10 Dietary Manager stated on 12/5/25, V10 observed V12 LPN standing at her med cart and she would start to fall asleep. She tried to put her key in the med cart to open it up but kept missing the keyhole because her eyes would shut. V10 stated she reported V12's behaviors to V1 Administrator on the morning of 12/2/25. V10 stated, I was told to keep an eye on her. I don't know what happened. (V12) was still working the floor when I left at 4PM that day.On 12/5/25 at 10:24 AM, V11 CNA stated on 12/2/5, she observed V12 LPN trying to put medication in a syringe but she was swaying back and forth while she was standing by the med cart. Her eyes kept closing and her head would [NAME] back and forth. Her behavior was unsafe. I wouldn't want her taking care of my loved one. V11 stated she reported V12's behaviors to V1 Administrator on 12/2/25. V11 stated, I was told to watch her by (V1). When I left at 1 PM that day, (V12) was still working the floor.On 12/5/25 at 10:32 AM, a telephone interview with V12 LPN was conducted. V12 denied being under the influence of drugs or alcohol but admitted she'd had a previous addiction to opioids and benzos (benzodiazepines) of which she was treated for in 2019. V12 stated on 12/2/25, she should have requested to go home that day because I was so tired. V12 stated she did at some point on 12/2/25 start to doze off if I sat down and her head may have bobbed or jerked because she was so tired. V12 stated she took a urine drug test on 12/2/25 that was given to her by V2 Director of Nursing (DON). V12 stated, My urine test was negative, so I went back to work and finished my shift. I was so tired I should have requested to go home after my test came back negative.On 12/5/25 at 11:03 AM, V1 Administrator stated he did receive concerns from V3 CNA, V4 CNA, V9 Housekeeping, V10 Dietary Manager, and V11 CNA about V12 LPN falling asleep at work on 12/2/25 around 10 AM. V1 stated around 11 AM that morning, V1 and V2 DON pulled (V12) in to talk to her. V1 stated, (V12's) eyes were open. We asked her if she needed any help. (V12) said she was just tired. We gave her a cup of coffee. We let her go back to work. She denied she had taken any drugs or alcohol. I kept watching her. Around lunchtime, I saw (V12) nod off and close her eyes. That's when we called our human resources, and they told us to drug test her. V1 stated V2 DON went to a local pharmacy to get a an over the counter (OTC) urine drug test because the facility did not have a contract with a local laboratory to have employees drug tested. V1 Administrator stated V12's OTC urine drug test was negative however V1 could not state exactly what drugs V12's urine was tested for and did not have any written results of V12's urine screen. V1 pulled out his cell phone and showed this surveyor a black and white pictures of an unlabeled and undated specimen cup. The cup |