Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	01/08/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure post fall assessments, to include vital signs, head to toe assessment and fall follow up, were completed for 2 of 3 residents (R1, R2) reviewed for quality of care in the sample of 3.The findings include:1. R1s admission record shows he was admitted on [DATE] with multiple diagnoses including adult failure to thrive, unspecified lack of coordination and weakness. The 11/11/25 annual resident assessment and care screening documents R1 to have severe cognitive impairment.R1s nursing progress notes of 10/8/25 show at 8:28 PM, he experienced a witnessed fall at the bedside. The roommate alerted staff R1 had rolled out of bed onto the floor. R1 reported he fell out of bed. R1 had no further assessments documented related to his fall.The 11/3/25 risk management report shows R1 was found lying on his right side on the ground at bedside. Fall mat in place. R1 reported he rolled over while in bed. The progress notes show no follow up assessments for 11/4/25. The post fall assessment for 11/5/25 includes the vital signs taken on 11/3/25.R1s nursing progress notes for 1/2/26 document he was sitting in bed and fell forward striking his face on the nightstand next to the bed. R1 was sent out to the emergency room and returned at 10:00 AM with sutures to the bridge of his nose. R1 had no further assessments documented for 1/2/26. On 1/3/26 at 2:39 PM, a follow up assessment was documented for the laceration to R1s nose. The progress notes show no further assessments or vital signs related to his fall. On 1/8/26 at 10:00 AM, V6 Registered Nurse (RN) said for resident falls, basically we do neuro checks for everyone. The incident should be documented in the progress notes it should say if the fall was witnessed or unwitnessed, skin assessment, physical assessment, pain assessment, it is all included in the forms we fill out. All falls are followed up every shift for 72 hours. A post fall evaluation form should be completed and that will generate a progress note. She said for the fall on 1/2/26, R1 should have charting for 1/3, 1/4, and 1/5. For the assessment, nursing should be getting a fresh set of vitals. She said it would be the same for 11/3/25, there should be documentation every shift for 3 days.On 1/8/26 at 12:34 PM, V2 Director of Nursing (DON) said the nurses are to follow the post fall tool. This tool includes monitoring every shift for 72 hours. The nurses should be assessing for any new pain or injury, or changes to their mobility. All this information would be charted in the notes.2. R2s admission record shows she was initially admitted to the facility on [DATE] with a history of falling. She had multiple diagnoses including dementia and bipolar disorder. Her 12/9/25 quarterly resident assessment and care screening documents her to have severe cognitive impairment.R2s nursing progress note dated 12/18/25 documents she had an unwitnessed fall in her room on 12/17/25 at 8:45 PM. She stated she fell and hit her face/head on the floor. The notes show she was sent out to the emergency room for evaluation. She returned to the facility and was placed back into bed. The progress notes were reviewed and show no follow up assessment related to this fall during the 72 hours following the incident.On 1/8/26, at 12:34 PM, V2 stated the nurses should have used the post fall too. And it is the DONs responsibility (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to review the documentation for compliance.The facility's undated Fall risk tool documents change of condition charting to be done every shift for 72 hours and includes a full set of vial signs and if skilled, head to toe assessment and fall follow up in notes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure fall interventions were in place for 1 of 3 residents (R1) reviewed for safety in the sample of 3.The findings include:R1s admission record shows he was admitted on [DATE] with multiple diagnoses including adult failure to thrive, unspecified lack of coordination and weakness. The 11/11/25 annual resident assessment and care screening documents R1 to have severe cognitive impairment.R1s nursing progress notes of 10/8/25 show at 8:28 PM, he experienced a witnessed fall at the bedside. The roommate alerted staff R1 had rolled out of bed onto the floor. R1 reported he fell out of bed. The 11/3/25 risk management report shows R1 was found lying on his right side on the ground at bedside. Fall mat in place. R1 reported he rolled over while in bed.R1s care plan of 11/11/24 documents he is a high risk for falls related to history of falling and poor safety awareness. The interventions include on 10/9/25, a floor mat at bedside while in bed. The intervention was revised on 11/3/25 following the second fall.On 1/8/26 at 9:44 AM, R1 was observed lying in bed on his left side facing the wall. He declined any questions from this surveyor. There was no fall mat located next to his bed, or in the room. On 1/8/26 at 9:50 AM, V5 Certified Nursing Assistant (CNA) said R1 transfers with 2 staff with a stand and pivot. She was not aware R1 had previous falls out of bed, and did not know he was supposed to have any fall mat next to the bed.On 1/8/26 at 10:00 AM, V6 Registered Nurse (RN) said (R1) should have a floor mat next to the bed. Most of the time during the day we keep him at the nurse's station, but If he is in bed he should have a fall mat next to his bed. V6 observed the room and no fall mat in place. She stated one should be placed.On 1/8/26 at 12:34 PM, V2 Director of Nursing stated it is the responsibility of nursing and management to ensure fall interventions are in place.The facility's 10/13/25 policy for accidents and supervision documents: The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 3. Implementing interventions to reduce hazards and risk. 4. Monitoring for effectiveness and modifying interventions when necessary.