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	06/17/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident to resident abuse did not occur for one of 5 residents (R1) reviewed for abuse in the sample of five. This failure contributed to R1 experiencing a fracture and increased pain in his right foot. The findings include:R1's admission Record dated June 16, 2026 shows he was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, asthma, morbid obesity, sleep disorder, depression, anxiety disorder, low back pain, and difficulty in walking. R1's Care Plan initiated May 26, 2026, shows, The resident is/has potential to be verbally aggressive (cursing at staff and other residents) related to ineffective coping skills, poor impulse control. When the resident becomes agitated: Intervene before agitation escalates; guide away from source of distress; engage calmly in conversation. R1's Minimum Data Set, dated [DATE] shows R1 is cognitively intact. R1 did not have any behavioral symptoms. R2's admission Record dated June 16, 2026 shows he was admitted to the facility on [DATE] with diagnoses including schizophrenia. R2's Care Plan revised on November 15, 2025 shows R2 has a conviction history-criminal damage to property. Needs additional monitoring to ensure respect of other resident's rights. Resident requires closer supervision and more frequent observation than standard or routine. Care Plan revised on November 21, 2025 shows R2 has potential to be physically and verbally aggressive related to history of harm to others and poor impulse control. R2's Care Plan revised on February 19, 2025 shows R2 has conviction history-physical assault related-battery with bodily harm. R2's Minimum Data Set, dated [DATE] shows he is cognitively intact. R2 did reject evaluation or care. On June 16, 2026 at 9:22 AM, R2 said him and R1 were talking to each other and R1 hit R2 in his head. It hurt. He kept on. He was being nasty. R2 said he told the nurse that R1 was not acting right that day. At 9:36 AM, R1 was interviewed in regards to the incident with R2. R1 said, He kind of whooped my a*s. I asked him to be quiet, he was talking in the middle of the night. I was trying to sleep. I told him to shut the f**k up. I was standing up, he pushed me into the door, he punched me in my head multiple times. he put his knee on my foot and broke my toe. I had a bruise to my left eye. I couldn't walk right for about a week and a half. The pain to my foot was bad. R1 said the incident happened in their room with the door closed. I didn't say anything until a few days later, cause I didn't know what was going to happen. He acted like nothing happened. I eventually told staff and they moved him out of my room. Aren't they supposed to protect us? R1 said he attempted to hit R2 back, but was not able to make any contact. R1 said that R2 told R1 that R1 was drunk. The facility's Investigation shows that R2 was interviewed on June 3, 2026. R2 said R1 came back to the facility drunk, R2 thought. R2 said R1 asked R1 how he got into the facility and R2 was telling R1 about R1's wife and R1's [NAME] car. R2 said that R1 yelled at R2 to shut up and then came over and punched R2 in the head. R2 stomped R2's foot onto R1's foot, and the altercation stopped. R1 was interviewed by the facility on June 3, 2026 and said he came back to the facility after being out on pass. R1 said R2 was talking, and R1 asked R2 to stop. R1 told R2 to shut the hell up.' R2 came over and punched R1 in the head. R1 said he did not know what R2 did to R1's toe, but it hurts and showed the interviewer his foot. R1 said he did not report it because R1 is not a sore loser, he just wanted R2 (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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	out of his room. A signed statement obtained by the facility on June 4, 2026 from V10 (Registered Nurse) RN shows R2 told V10 that he reported the incident to a nurse after it happened. R1's Progress Note dated June 4, 2026 at 11:43 AM shows, Resident finally told the RN (Registered Nurse) how he thinks he got the toe fracture. Resident states that he and his roommate got into a verbal altercation Saturday night (May 30, 2026) and that while this resident and his roommate (R2) were arguing, residents roommate got into his face and fell into his body and onto his toe. The roommate admitted to 'stomping on [R1's] foot.' This RN asked resident why he didn't tell any staff until he told administration yesterday and this RN today and the resident states he was a little embarrassed and 'didn't want to admit he got bullied.' Resident told this RN that the only reason why he told administration yesterday is because he wanted the roommate out of his room .The (Director of Nursing/DON) reached out to the doctor and got an order for an X-Ray because the resident complained of toe pain. R1's Skin Check dated June 3, 2026 shows, Right dorsum foot. 2-4th dorsal proximal toes issue: bruising. Evaluate for occurrence of trauma as a cause. R1's Radiology Results Report dated June 3, 2026 shows, Recent fracture of the proximal phalanx right 2nd toe. Subacute/old fracture right 5th metatarsal bone. Soft tissue swelling. On June 16, 2026, V1 Administrator was interviewed in regards to the incident. V1 said that R1 told her that R1 returned to the facility from his outside pass and R2 was conversing with R1. R2 asked R1 to stop and R2 did not stop. R1 to V1 that R2 got up and punched R1. R2 admitted to stomping on R1's foot. V1 said that no staff heard the altercation. V1 said she did not substantiate abuse during her investigation, V1 considered the incident a disagreement. They did not want to pursue charges. I considered it an argument. At 2:59 PM, V2 (Director of Nursing/DON) said she saw bruising to R1's top of right foot from his 2nd toe to his 4th toe. V2 said R1 complained of pain when he stood up. At 8:33 AM, V6 Social Services Director said the incident happened over the weekend. V6 said herself and V1 talked with R2. V6 said R2 told her that R1 returned to the facility from a pass and was acting weird, but R2 was not specific. The facility's Abuse, Neglect, and Exploitation policy dated 2025 shows, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and document review, the facility failed to ensure medications were documented as administered on the Medication Administration Record (MAR) after administration for 1 of 5 residents (R4) reviewed for medication administration in the sample of 5.The findings include:On 6/16/26, R4's Medication Administration Record (6/1/26-6/16/26) showed that R4 did not receive the following medications on 6/9/26 at 9:00AM as ordered: ferrous sulfate 325mg (milligram), folic acid 1mg, gabapentin 300mg, pyridoxine 25mg, carvedilol 3.125mg, Keppra 500mg, and amoxicillin 500mg.On 6/16/26, R4's Medication Admin (Administration) Audit Report for 6/9/26 showed that R4 did not receive the medications as ordered.On 6/16/26 at 1:00PM, R4 stated he did not receive morning medications on 6/9/26. R4 stated that this can occur when there is an agency nurse as they are not always familiar with the residents and at times the residents will have to go looking for the nurse to receive their medications.On 6/16/26 at 3:00PM, V2 (Director of Nursing) stated that medications are to be documented within the MAR upon administration to the residents. At this time, V2 reviewed R4's MAR (medication administration record) and Medication Audit Report and confirmed the documents indicated that the medications were not administered.On 6/17/26, the facility emailed signed attestations by V2 (Director of Nursing), V9 (Licensed Practical Nurse), and R4 documenting that physician orders for medications were administered but not documented at the time of administration due to oversight. The attestations do not include the date, time, or medications that were administered.The facility's Medication Administration policy (reviewed/revised: 6/26) documented that medications are administered as ordered by the physician and in accordance with professional standards of practice that include signing of MAR after medications are administered.