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	06/30/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review the facility failed to notify a resident's power of attorney - POA of the residents fall for 1 of 3 residents (R1) reviewed for notification in the sample of 7.The findings include:The Incident Report dated 6/8/26 for R1 showed the certified nursing assistant notified the nurse that R1 was on the floor in her room during rounds. The description showed that the resident fell and landed on her knees in her room. The form showed the physician was notified; there was no documentation of the POA being notified.On 6/30/26 at 9:35 AM, R1 stated she has had two falls and each time they didn't ask if she needed to go to the hospital. R1 said she went to the hospital recently and her power of attorney was notified by the hospital; not by the staff there (at facility).On 6/30/26 at 9:43 AM, V4 Nurse Practitioner stated after a resident falls the provider, director of nursing, and power of attorney should be notified.On 6/30/26 at 10:35 AM, V6 registered Nurse - RN stated that she did not notify V7 (R1's POA) after R1 fell on 6/8/26. V6 stated since it was early in the morning she did not call V7. Normally they call the POA but she was going to wait until waking hours to do it and then didn't call. V6 stated when R1 came back from the hospital on 6/20/26, not related to the fall, V7 was called and that was when V7 stated she was not getting calls like she should.On 6/30/26 at 1:00 PM, V3 Assistant Director of Nursing - ADON stated after a resident falls the POA is notified; they will call immediately if an injury occurs otherwise they wait until waking hours. V3 stated she would have called the POA at around 8:00 AM.The face Sheet dated 6/30/26 for R1 showed diagnoses including malignant neoplasm of upper lobe bronchus or ling, cellulitis, bipolar disorder with mixed severe psychotic features, borderline personality disorder, post-traumatic stress disorder, suicidal ideation, iron deficiency, depression, aneurysm, anxiety disorder, GERD, chronic pain, nausea, malignant neoplasm of upper lobe left bronchus, insomnia, toxic liver disease, chronic viral hepatitis, epilepsy, and acute interstitial pneumonitis.The facility's Fall Prevention Program policy (2025) showed, when any resident experiences a fall, the facility will: notify the physician and family.

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	06/30/2026

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. Based on observation, interview, and record review the facility failed to ensure a complete assessment was done and documented after a residents fall for 1 of 3 residents (R1) reviewed for falls and assessments in the sample of 7.The findings include:The Incident Report dated 6/8/26 for R1 showed the certified nursing assistant notified the nurse that R1 was on the floor in her room during rounds. The description showed that the resident fell and landed on her knees in her room. The fall was unwitnessed. The Incident report was not completely filled out in the areas of level of pain, level or consciousness, mobility, or mental status. There was no documentation of R1's vitals signs.The Progress Notes for R1 showed on 6/9/26 at 5:39 AM, Certified Nursing Assistant - CNA heard yelling, entered the room and the resident was on the floor. No vital signs were documented or a complete assessment of what the nurse evaluated for the resident post fall.The Progress Notes for R1 for 72 hours after her fall were reviewed and showed a post fall evaluation completed on 6/11/26 and a fall risk evaluation on 6/11/26. The facility did not have ongoing post-fall documentation including any assessments, vital signs or neurological evaluation during the 72 hours after her fall.On 6/30/26 at 9:35 AM, R1 was lying on top of her bed, completely dressed with regular grey socks on; no grips to the socks were noted. R1's wheelchair was next to her bed. R1 did not have any shoes out in the open in her room. R1 stated she had two falls and each time they didn't ask if she needed to go to hospital. R1 stated she told them the second time she fell that she wanted to go to the hospital, and she was told that she did not need to go. R1 stated she told them that she had pain in her left side. R1 stated she was in her wheelchair, her foot got caught under her chair and she fell out of her chair onto the floor. R1 stated the staff came in, picked her up, and put her in her bed. R1 stated the nurse did not come and check her. R1 stated she was given some pills and put in bed and that was all that was done. On 6/30/26 at 9:43 AM, V4 Nurse Practitioner stated after a resident falls the nurse should assess the resident, check vital signs and start neurological checks if it is an unwitnessed fall. V4 stated the assessment should be documented after the residents' fall.On 6/30/26 at 1:00 PM, V1 Administrator and V3 Assistant Director of Nursing were present and interviewed. V3 stated the expectation for nursing after a resident has a fall is to immediately assess the resident, ask them what they were doing, why they fell and try to figure out the situation. V3 stated an assessment is done, vital signs are checked, range of motion is checked and then a decision is made if they need to be sent out or can be treated in the facility. If the fall was unwitnessed then neurological checks are done. The assessment and vital signs are entered into the charting. The post fall charting is initiated. V3 reviewed R1's medical record and stated it did not show a complete assessment for R1 after her fall on 6/8/26. V3 stated she did not see the 72 hour post fall charting or neurological assessments in R1's medical record. V3 stated the documentation did not reflect the facility's policy.The face Sheet dated 6/30/26 for R1 showed diagnoses including malignant neoplasm of upper lobe bronchus or ling, cellulitis, bipolar disorder with mixed severe psychotic features, borderline personality disorder, post-traumatic stress disorder, suicidal ideation, iron deficiency, depression, aneurysm, anxiety disorder, GERD, chronic pain, nausea, malignant neoplasm of upper lobe left bronchus, insomnia, toxic liver disease, chronic viral hepatitis, epilepsy, and acute interstitial pneumonitis.The facility's Fall Prevention Program policy (2025) showed, when any resident experiences a fall, the facility will: assess the resident, complete a post-fall assessment, complete an incident report, and document all assessments and actions.