

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER LA Bella of Rochelle		STREET ADDRESS, CITY, STATE, ZIP CODE 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 prevent a resident to resident abuse for two residents (R4 & R5) reviewed for abuse on the sample list of 11. This facility failure resulted in R4 sustaining a thoracic fracture and being sent to the hospital. Findings include: The facility face sheet for R4 shows he has the following diagnoses to include schizoaffective disorder bipolar type, chronic obstructive pulmonary disease and epilepsy. The facility assessment dated [DATE] for R4 shows him to have severe cognitive impairment and requires supervision for ambulation with a walker. The facility face sheet for R5 shows he was admitted to the facility with a diagnosis of schizoaffective disorder bipolar type. The facility assessment dated [DATE] shows R5 to be cognitively intact and requires supervision for his activities of daily living. A nursing note dated 7/16/26 at 1:39 PM shows R5 was shining a flash light into R4's face. R4 got up and attempted to throw his walker at R5 causing them both to fall to the ground at the same time. The note goes on to show the staff attempted to stop the residents from kicking at each other as they lay on the ground. The note shows the residents were separated and assessments were completed on both residents. R4 was found to have 3 scratches to his left cheek and a skin tear to his right hand. The nursing note dated 7/15/26 at 4:34 PM, shows a physical resident to resident altercation. The note shows the staff intervened immediately and 911 had been called. R4 refused treatment at the local hospital and from EMS (Emergency Medical Services). Abrasions were identified to R4's left side of his face and the area was cleansed. The nursing note dated 7/15/26 at 7:45 PM, shows follow-up assessments to R4 showed complaints of significant pain to his low to middle back that became worse upon movement. R4 was sent to the local emergency room. The local hospital records shows R4 was seen in the emergency room for evaluation of injuries suffered in an assault with another resident. A CT scan (Computed Axial Tomography) was completed on 7/15/26 and showed significant calcification on the ligaments with a disruption at the T 9-10 level. (Thoracic spine) If patient is symptomatic an MRI (Magnetic Resonance Imaging) is recommended. The hospital records also show on 7/16/26 a MRI scan was completed and showed an acute fracture of the calcified anterior ligament at the T9-10 level. The records then show R4 was transferred to a larger hospital for a neurology consultation for possible surgical repair. The discharge summary from the larger hospital R4 was sent to dated 7/21/26 shows fracture involving the calcified anterior longitudinal ligament at the T9-10 level. On 7/22/26 at 10:00AM, R7 said she was sitting in the activity room when R4 and R5 had there fight. R7 said R5 shined a light into R4's face and R4 stood up and went to raise his walker at R5 when they both fell into each other and fell to the ground. R7 said she screamed for the staff to come help. On 7/22/26 at 10:13 AM, R6 said she was also sitting in the activity room when R4 and R5 had a fight. R6 said she saw a flash of light out of the corner of her eye and then she turned towards R4 and R5 and (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.	saw R4 standing up and going towards R5 with his walker, but they both fell to the ground. On 7/22/26 at 10:19 AM, R11 said she saw R5 shine a light into R4's face and then she saw R4 get up and go towards R5 to try and hit him with the walker, but they both fell to the ground. On 7/22/26 at 9:40 AM, V11 and V20 both CNA's (Certified Nursing Assistant) said they were both headed down a hall to help a resident when they heard yelling and screaming. They both turned and ran to the noise in the activity room and saw R4 and R5 on the floor with staff trying to separate them. On 7/22/26 at 9:37 AM, V19 RN (Registered Nurse) said she was the nurse for R4 the day of the altercation between R4 and R5. V19 said she did not see what happened prior to the yelling by the other residents in the activity room. V19 said when she got there, she saw R4 and R5 both on the floor wiggling around. V19 said V4 and V17 were on the floor trying to separate the two residents. On 7/22/26 at 10:04 AM, V4 Maintenance Director said he responded to the activity room after hearing the resident yelling. V4 said when he got there both R4 and R5 were on the ground. V4 said he pulled R4 and R5 apart to stop them from fighting. On 7/22/26 at 10:06 AM, V17 Housekeeper said he was in the janitor closet next to the activity room and heard the residents yelling loudly, so he went out to the activity room right away. V17 said both residents were already on the floor and he pulled them apart to stop the fight. On 7/22/26 at 9:45 AM, V2 DON (Director of Nursing) and V5 ADON (Assistant Director of Nursing) said they were in a meeting with other management staff in the office across from the activity room when they heard residents yelling and screaming. They said R4 and R5 were already on the ground and V4 and V17 were separating them when they opened the door. V2 said she called 911 and went to assess both residents. V2 said R4 had some cuts to his hand and the left side of his face but refused to go to the emergency room when the paramedics arrived. V2 said R5 had no apparent injuries. V2 said later that same day R4 began to complain of pain to his back and agreed to get it checked out at the hospital. On 7/22/26 at 12:15 PM, V1 Administrator said she expects the staff to be supervising the residents when they are in the activity room to prevent any incidents and to de-escalate any problems the residents may be having with each other. The undated abuse policy for the facility shows that this facility is to provide protections for the health, welfare and rights of each resident. The prevention of abuse shows identifying, correcting and intervening in situations in which abuse is more likely to occur. The facility final investigation summary of the incident shows the conclusion of the report shows that a resident to resident conflict escalated into a physical altercation involving both residents.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to thoroughly investigate a resident-to-resident sexual abuse allegation involving a resident (R1) with impaired cognitive abilities. This applies to two of five residents (R1 & R2) reviewed for abuse in the sample of 11. The findings include: The facility face sheet for R1 shows her to have diagnoses to include but not limited to dementia, Pick's Disease (a rare irreversible neurodegenerative condition, a type of dementia), mild intellectual disability and schizoaffective disorder bipolar type. The facility assessment dated [DATE] shows her to have moderate cognitive impairment and requires moderate assistance with her activities of daily living. The facility face sheet for R2 shows he was admitted to the facility with diagnoses to include but not limited to Chronic Obstructive Pulmonary Disease, hypertension and anemia. The facility assessment dated [DATE] shows R2 to be cognitively intact and uses a wheelchair for his ambulation. A nursing progress note dated 7/16/26 shows the nurse (V9 Registered Nurse) receiving report at the start of her shift. V9 wrote she was told that R1 had a [NAME] to her neck that she received on the night shift of 7/15/26 from male resident (R2). V9 wrote she reviewed R1's record and saw no documentation the incident had been reported, so she notified the abuse coordinator (V1 Administrator) and was told she would call her back. V9 then called the Physician for R1 (V3) and was told to follow the protocol regarding abuse. V9 then called the local police and the POA (Power of Attorney) for R1. On 7/21/26 R1 was observed self-propelling herself in her wheelchair all over the facility. R1 was observed at times talking to herself and moving quickly throughout the facility. A small faint red discoloration was observed in R1's left neck. At 10:19 AM when asked about the [NAME] to her neck, she stated, Nothing happened, I don't want to talk about it. R1 repeated this statement numerous times. On 7/21/26 at 12:03 PM, V9 (Agency Registered Nurse) said she came into work on 7/16/26 and was told in report that R1 had a [NAME] to her neck and it had happened on the overnight shift by R2. V9 said she was told to keep an eye on R1 as she was not able to give consent for this. V9 said she reviewed R1's record and saw no documentation of the incident and called the abuse coordinator to report what she had heard. V9 said V1 told her she was on vacation and would call me back, but she never did. V9 said she then called V3 (R1's Physician) to report what she had heard and was told by V3 to follow the abuse protocol. V9 said she then called the local police and left a message for R1's POA. V9 said when she tried to talk to R1 about it, R1 was not able to answer any questions and was rambling with her speech. On 7/21/26 at 12:11 PM, V10 RN said she came on her shift at 6 AM on 7/16/26 and was asked by V12 (Housekeeper) to come look at R1's neck stating it looked like she had a [NAME] on her neck. V10 said she texted the ADON (Assistant Director of Nursing) and told her what was found. V10 said the ADON and the DON (Director or Nursing) arrived at the facility and took over the situation. On 7/21/26 at 12:55PM, V12 Housekeeper said she was cleaning the lobby and she R1 wheel past her and she noticed a bruise to her neck that looked like a [NAME]. V12 said she went and told the nurse right away. On 7/21/26 at 12:25 PM, V4 Maintenance Director said when he came to work on 7/16/26 he was told that R1 had a [NAME] on her neck. V4 said he went and reviewed the video footage of the night before and saw R1 and R2 kissing and hugging in a dark activity room. R2 then wheeled himself towards his room and R1 followed him. On 7/21/26 at 2:00 PM, V2 ADON said she had watched the video, and the time stamp was for 7/16/26 at 12:06AM. On 7/21/26 at 11:56AM, V3 (R1's Physician) said he has cared for R1 for a very long time and feels it's a gray area trying to determine if she is able to give consent for this type of interaction with a peer. R1 would be receptive to any attention someone would try to give her. On 7/21/26 at 1:50 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	PM, V15 (R1's sister) and POA said she was called about the incident and said she wishes she wasn't involved in the situation. R1 was abused sexually by her husband and has always liked the boys. V15 said she thinks R1 is still capable of giving consent but is not 100% sure. On 7/21/26 at 7:34 PM, V16 (Police Officer) said he came to the facility on 7/16/26 around 8PM. V16 said he was told a resident had a [NAME] on her neck and she is not capable of giving consent. V16 said he met with the woman, and she was not able to even complete a full sentence and was not making any sense. V16 said he then spoke with the man involved and he admitted to kissing and hugging the woman and giving her a [NAME] on her neck. V16 said some of the staff reported to him that the woman is able to give consent, and she knew what she was doing. V16 said he was not completely sure about that, and the case was handed over to a detective. On 7/21/26 at 10:40 AM, V2 DON said R1 and R2 are just friends and will hold hands and hang out. V2 said R1's POA is aware and has no concerns. V2 said she told R1's Physician that R1 and R2 are just friends and the family is fine with it. V2 said the police officer said R1 is allowed that friendship. On 7/22/26 at 12:15 PM, V1 Administrator said when the situation is a Grey area it should be investigated. The social services quarterly assessment dated [DATE] for the section trauma factors including abuse/neglect it asks for factors that increase the resident vulnerability e.g. dementia, poor insight, poor communication skills. The question was answered yes. The abuse/neglect screening dated 5/2/26 shows R1 is at high risk for abuse. The Psychiatry note dated 7/1/26 for R1 shows the resident demonstrates expected neurocognitive decline but is able to engage in somewhat meaningful conversation. The mental status exam showed limited insight and judgement, fair memory and fair attention span. The undated abuse policy from the facility shows an immediate investigation is warranted when suspicion of abuse occurs.		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have interventions in place to protect a cognitively impaired resident from potential abuse. This applies to one of five residents (R1) reviewed for abuse in the sample of 11. The findings include: The facility face sheet for R1 shows her to have diagnoses to include but not limited to dementia, Pick's Disease (a rare irreversible neurodegenerative condition, a type of dementia), mild intellectual disability and schizoaffective disorder bipolar type. The facility assessment dated [DATE] shows her to have moderate cognitive impairment and requires moderate assistance with her activities of daily living. A nursing progress note dated 7/16/26 shows the nurse (V9 Registered Nurse) receiving report at the start of her shift. V9 wrote she was told that R1 had a [NAME] to her neck that she received on the night shift of 7/15/26 from male resident (R2). On 7/21/26 R1 was observed self-propelling herself in her wheelchair all over the facility. R1 was observed at times talking to herself and moving quickly throughout the facility. A small faint red discoloration was observed in R1's left neck. At 10:19 AM when asked about the [NAME] to her neck, she stated, Nothing happened, I don't want to talk about it. R1 repeated this statement numerous times. On 7/21/26 at 12:03 PM, V9 (Agency Registered Nurse) said she came into work on 7/16/26 and was told in report that R1 had a [NAME] to her neck and it had happened on the overnight shift by R2. V9 said she was told to keep an eye on R1 as she was not able to give consent for this. V9 said she reviewed R1's record and saw no documentation of the incident and called the abuse coordinator to report what she had heard. V9 said when she tried to talk to R1 about it, R1 was not able to answer any questions and was rambling with her speech. On 7/21/26 at 12:25 PM, V4 Maintenance Director said when he came to work on 7/16/26 he was told that R1 had a [NAME] on her neck. V4 said he went and reviewed the video footage of the night before and saw R1 and R2 kissing and hugging in a dark activity room. R2 then wheeled himself towards his room and R1 followed him. On 7/22/26 at 9:45 AM, V5 ADON said R1 likes to seek out male attention and wanders around the facility on her own. R1 can be talking normal one minute and then the next minute she will be in own little world and not be making any sense. On 7/22/26 at 10:00AM V2 DON (Director of Nursing) said R1 seeks out other residents for attention. She will wander around the facility and will go into other resident rooms seeking attention. R1 likes the male residents. V2 said the staff try to keep her busy and redirect her as needed. On 7/22/26 at 10:24 AM, V18 Social Service Director said R1 likes to wander around the facility in her wheelchair. V18 said R1 likes to seek out attention from the male residents. V18 said the staff try and redirect her away from this type of behavior. On 7/21/26 at 11:56AM, V3 R1's Physician said he has cared for R1 for a very long time and feels it's a gray area trying to determine if she is able to give consent for this type of interaction with a peer. R1 would be receptive to any attention someone would try to give her. V3 said the facility staff should be closely monitoring R1. On 7/21/26 at 1:50 PM, V15 R1's sister and POA said she was called about the incident and said she wishes she wasn't involved in the situation. R1 was abused sexually by her husband and has always liked the boys. V15 said she thinks R1 is still capable of giving consent but is not 100% sure. On 7/21/26 at 7:34 PM, V16 (Police Officer) said he came to the facility on 7/16/26 around 8PM. V16 said he was told a resident had a [NAME] on her neck and she is not capable of giving consent. V16 said he met with the woman, and she was not able to even complete a full sentence and was not making any sense. The social services quarterly assessment dated [DATE] for the section trauma factors including abuse/neglect it asks for factors that increase the resident vulnerability e.g. (continued on next page)		

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