STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000012	A. BUILDING: _____ B. WING _____	C 04/15/2025

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LA BELLA AT CLIFTON	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

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S 000	Initial Comments Complaint Investigations: 2562896/IL189399 2562994/IL189595	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2: 300.690a) 300.690b) 300.690c) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional	S9999		

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S9999	Continued From page 1	S9999		

Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

This Requirement is NOT MET as evidenced by:

Based on interview and record review, the facility failed to report a fracture to the state survey agency for one (R4) of three residents reviewed for falls in the sample list of 14.

Findings include:

The Facility's Undated "Accidents and Injuries - Investigating and Reporting" Policy documents, All accidents or incidents involving residents, employees, visitors, vendors occurring on the facilities premises shall be investigated and reported to the administrator. The Nurse/supervisor/charge nurse and or the department director or supervisor shall complete a risk management form within 24 hours of the incident or accident. This document also follows current rules and regulations governing reporting accidents and/or incidents to appropriate government agencies.

R4's Fall Report dated 1/21/2025 at 2:15 PM documents R4 attempted to step into the transport van, lost balance, and fell.

R4's right foot x-ray dated 1/23/2025 documents an age indeterminate cortical step off of the first and fifth toes. This x-ray documents clinical indication was swelling, discoloration, and pain. The investigative file for R4's 1/21/24 fall,

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provided by V2 Director of Nursing, did not contain documentation that R4's toe fractures were reported to the state survey agency.

On 4/14/25 at 2:58 PM V27 Radiology Technician stated R4's 1/23/25 x-ray results indicate a fracture if the injury was related to a fall.

On 4/14/25 at 3:00 PM, V2, Director of Nursing stated R4's fracture wasn't reported to the state survey agency.
(C)

Statement of Licensure Violations 2 of 2:
300.610a)
300.1210b)
300.1210d)6)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological

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well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:
These Requirements were not met as evidenced by:
6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Based on observation, interview, and record review the facility failed to protect a resident's (R1) right to be free from physical abuse by another resident (R2). This failure affects two (R1, R2) of seven residents reviewed for abuse in the sample list of 14. This failure resulted in R2 abusing R1, causing R1 to experience psychosocial harm as evidenced by crying and fear of R2.

Findings include:

On 4/14/25 at 8:14 AM R1 was in a wheelchair and slowly propelled herself into her room. R1 stated R1 wishes another resident, R2, wasn't here in the facility. R1 stated a couple weeks ago around 5:00 PM, while in the main dining room, R2 hit R1 in the back of the neck. R1 demonstrated this with an open palm. R1 stated this caused R1 to have neck pain for a few days

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after the incident. R1 stated this incident was witnessed by V4 Certified Nursing Assistant (CNA). R1 stated R1 is afraid of R2 and every time R2 goes past R1, R1 gets all "shaky and nervous". R1 stated R2 has Alzheimer's and R1's mother was the same way. R1 stated R1's mother used to spank R1, pinch R1, and pull R1's hair whenever R1 had an incontinence accident; and this incident brings back those memories.

On 4/14/25 at 11:45 AM R2 was walking by herself, pushing a wheelchair out of the activity room. At 11:53 AM R2 was interviewed regarding the incident with R1. R2 did not recall the incident and was confused.

R1's Minimum Data Set (MDS) dated 3/18/25 documents R1 is cognitively intact, requires substantial/maximal assistance from staff for transfers, and does not walk.

R2's Admission MDS dated 2/10/25 documents R2 has severe cognitive impairment, physical/verbal/other behaviors noted one to three days during the review period, and these behaviors put others at risk for injury and significantly disrupts care or living environment. R2's Nursing Note dated 3/29/2025 at 5:30 PM documents R2 was near the nurse's station yelling "shut the F**** (expletive) up, motherf****** (expletive)" and banging on the walls. Attempts at redirection were unsuccessful. R2's Behavior Monitoring and Intervention Report dated 3/17/25-4/15/25 documents R2 had aggression towards others on 10 days.

The facility's Daily Nursing Schedules dated 4/1/25 and 4/2/25 document V4 CNA worked the evening shift and was assigned to monitor the main dining room.

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S9999	Continued From page 5 On 4/14/25 at 9:14 AM V4 CNA stated on an unidentified date within the last month, around 4:30-5:00 PM, R1 and R2 were in the dining room. V4 stated R2 wheeled past R1 in her wheelchair, R2's wheelchair got stuck and couldn't get past R1. V4 stated R2 got upset with R1 and smacked R1 in the back of the neck with R2's hand. V4 stated V4 ran over there as fast as she could to get R1 out of the way. V4 confirmed V4 considered R2's actions as abuse. V4 stated R2 has hit staff during cares, has outburst and swats at people as they walk past her. V4 stated R1 cries now every time R1 sees R2 and tells the staff that R2 had hit R1. On 4/14/25 at 9:28 AM V18 Licensed Practical Nurse (LPN) stated it was reported to V18 that R1 does not like R2 around and "freaks out". V18 stated V18 did not witness but was told that R2 had hit R1 on the back of the neck in the dining room, and this was reported by an unidentified CNA on an unidentified date. V18 stated when R1 has an experience, R1 doesn't forget it. On 4/14/25 at 9:50 AM V21 Activity Director stated on the morning of 4/4/25, R1 told V21 that R2 had smacked R1 in the back of the head. V21 stated V21 had been off work that week and returned on 4/4/25 and the incident happened sometime that week. V21 stated R1 said R1 did not want to be around R2, and inferred that R1 was afraid of R2. V21 described R1 as being sad when R1 reported this. V21 stated R1's mother had dementia and would spank R1 when R1 was incontinent and R1 is very fearful due to her history with her mother and not having the ability to run away from others. V21 stated R1 does not have any memory problems.	S9999		

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S9999	Continued From page 6 On 4/14/25 at 12:44 PM V8 LPN stated there was a day within the last couple weeks that R1 would not go into the activity room because of R2. V8 stated R1 was crying but V8 could not understand R1 or why R1 was upset with R2. V8 stated V8 took R1 to her room to calm down. The facility's Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated as revised March 2025, documents residents have the right to be free from abuse and abuse includes the willful infliction of injury with resulting physical harm, pain or mental anguish. (B)	S9999		