

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000861		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/24/2026	
NAME OF PROVIDER OR SUPPLIER La Bella of Morrison				STREET ADDRESS, CITY, STATE, ZIP CODE 500 NORTH JACKSON STREET , MORRISON, Illinois, 61270			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
S0000	Initial Comments Complaint Investigations 2612003/2746022 2612004/2746040		S0000				
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.690b) 300.690c) 300.1210b) 300.1210c) 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. 300.690 Incidents and Accidents 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		S9999				

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 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 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. 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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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. These requirements are not met as evidenced by: A. Based on interview and record review the facility failed to safely transfer residents and, in a manner, to prevent resident falls and injuries for 2 of 5 residents (R1, R3) reviewed for resident safety and supervision in the sample of 7. This failure resulted in R1 sustaining a large leg skin laceration, during a transfer, that required emergent transport to a local hospital for suture repair. B. Based on interview and record review the facility failed to notify the Illinois Department of Public Health (IDPH) of an incident that resulted in a serious resident injury for 1 of 3 residents (R1)			S9999			

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S9999	Continued from page 2 reviewed for accidents and incidents in the sample of 7. The findings include: 1.R1's progress notes and hospital records dated 1/23/26 showed R1 sustained a laceration to her left lower leg while being transferred into bed by facility staff. R1 was emergently transported via ambulance to a local hospital for an evaluation of her laceration. R1's leg laceration was repaired with nine (9) sutures. R1 was discharged back to the facility on antibiotics for the laceration and with orders to follow up with the hospital's wound care team. R1's admission physical therapy evaluation dated 1/8/26 showed, "Per consultation, patient demonstrated fear of falling as evidenced from patient getting anxious and unable to stand with 1 person assist despite max assistance given. Patient demonstrated severe posterior lean when attempted to stand. Patient was able to stand with CGA (contact guard assistance) of 2 people..." The evaluation showed R1 required the assistance of 2 staff for transfers and standing. On 2/23/26 at 11:16 AM, V7 Certified Nursing Assistant (CNA) stated she was transferring R1, from her wheelchair to the bed, on 1/23/26 when R1's leg laceration occurred. V7 stated, "It was my first time taking care of her, so I didn't know how she transferred. I went to stand her up and she started freaking out. She became frantic and panicked which made me anxious, so I just hurried up and got her on the bed. She immediately said her leg was hurting. I pulled up her pant leg and saw a big skin tear. My guess is that her leg got caught on the leg of the wheelchair when I was transferring her... I should have stopped and gotten someone else to help me move her. I should have given her time to calm down." On 2/23/26 at 2:19 PM, V12 Restorative Nurse stated to ensure R1's safety, R1 should be transferred by two staff due to her extreme anxiety and fear of falling. On 2/23/26 at 12:11 PM, V10 Medical Director stated staff are to transfer residents in accordance with the recommendations made by skilled therapy or restorative services. V10 stated his expectation is that residents are not injured while being cared for by staff. On 2/23/26 at 10:54 AM, V2 Director of Nursing (DON) stated, "Incidents that are to be reported to			S9999			

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S9999	Continued from page 3 IDPH are falls and incidents that cause major injuries to residents like fractures and lacerations that require stitches." V2 stated she did not report R1's incident on 1/23/26 to IDPH. V2 stated, "I reported the incident to (V1 Administrator). I am not sure why it wasn't reported." On 2/24/26 at 2:51 PM, V1 Administrator stated she never reported R1's incident on 1/23/26 to IDPH. V1 stated the facility did not have a policy on incidents involving serious resident injury to IDPH. 2.R3's care plan dated 11/5/25 showed R3 had history of falls in the facility. R3 was at risk for falls due to her impaired cognition and the paralysis of her right arm and right leg due to a previous stroke. R3 was nonverbal. The plan showed R3 required the use of a gait belt and the assistance of one staff for transfers, standing, and ambulation. R3's fall incident report dated 1/27/26 showed R3 sustained a fall in her bathroom while being cared for by V4 CNA. R3 struck her head on the sink as she fell. R3 complained of right leg pain post-fall. R3 was emergently transported by ambulance to a local hospital for an evaluation. R3's hospital radiology studies were negative for any fractures or injuries. R3 was discharged back to the facility on 1/27/26. On 2/23/26 at 2:04 PM, V4 CNA stated on 1/27/26, she assisted R3 to a standing position, off the toilet, without using a gait belt. V4 stated, "When I turned away from (R3) to take off my gloves and wash my hands, she fell to the ground. I wasn't holding onto her at all when she fell." On 2/23/26 at 2:19 PM, V12 Restorative Nurse stated staff are to use a gait belt when transferring R3. The facility's Use of Gait Belt policy dated 10/13/25 showed, "It is the policy of this facility to use gait belts with residents that cannot independently ambulate or transfer for the purpose of safety..." (B)			S9999			