STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145222	A. Building B. Wing	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Bella of Woodstock	309 McHenry Avenue Woodstock, IL 60098

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free from misappropriation for one of four residents (R2) reviewed for misappropriation in the sample of four. This past noncompliance occurred from August 14, 2025-August 14, 2025.Findings include:R2's admission Record dated August 25, 2025, shows he was admitted to the facility on [DATE], with diagnoses including hemiplegia, chronic obstructive pulmonary disease, major depressive disorder, and anxiety disorder.R2's Care Plan initiated July 17, 2025, shows R2 is functioning at an independent level in his leisure pursuits. He is alert, oriented and able to express his needs, desires, and opinions. R1's admission Record dated August 25, 2025, shows she was admitted to the facility on [DATE], with diagnoses including diabetes mellites II, syphilis, adjustment disorder, schizophrenia, ataxia, and depression.R1's Care Plan initiated August 15, 2024, shows R1 displays behavioral symptoms that are manifested by always asking peers, staff and visitors for money and snacks. On August 25, 2025, at 10:48 AM, V5 Social Services Director said she was walking near the vending machines when R1 had someone's wallet and R1 handed it to V5. V5 said V6 Certified Nursing Assistant (CNA) went into the dining room and told V5 that the wallet belonged to R2. V5 said that R1 had a credit card that had R2's name on it. V5 said that R1 said she found the wallet laying around but did not say where she found it. V5 said that R2 reported there was money missing from his wallet. V5 said facility staff searched for R2's money but could not find it. At 1:52 PM, V6 CNA said R1 asked him to help her use the vending machine by sliding a card. V6 said he swiped the card and realized it didn't belong to R1. V6 told R1 that she can't be using someone else's card. V6 said that R1 told him to hush and snatched the card back. V6 said he went to R2's room to ask R2 if he gave R1 permission to use his card and R2 said no. R2 told V6 that he has been looking for his wallet. V6 returned R2's wallet to R2 and R2 looked into his wallet and said there was money missing. V6 said he walked back into the dining room and R1 was sitting next to another resident and R1 told the other resident that she had $100 cash. The other resident asked her where she got it and V6 said that R1 was telling the other resident to be quiet since V6 was nearby. V6 said that R1 is smart and she knows what she's doing in regard to taking things that don't belong to her.On August 25, 2025, at 9:43 AM, V3 Corporate Nurse said that R1 said she found R2's wallet on the floor in R2's room. V3 said when R2 was interviewed about his missing wallet, R2 said he had $100 in his wallet that was missing. V3 said that other staff have seen R2 with cash, so the facility reimbursed R2 $100. V3 said that R1 said she did not take any money out of R2's wallet. V3 said that R1 has taken things in the past from others that don't belong to her. V3 said that R1 takes things when the things are not in the right place. On August 25, 2025, at 11:33 AM, R2 said that R1 came into his room and took his wallet. R2 said the facility staff told him that R1 used his debit card. R2 said his cash was missing from his wallet. R2 said he did not give R1 permission to take his wallet or use his debit card. At 1:25 PM, R1 said she was visiting with R2 in R2's room. R1 said that R2's wallet was on the floor in R2's room and she picked it up. R1 said before she returned the wallet to V5, she used R2's debit card to buy a pop. R1 denied taking cash out of R2's wallet. The facility's Abuse, Neglect and Exploitation policy dated November 2024 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. Misappropriation of Resident Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belonging or money without the resident's consent.Prior to the survey date of August 25, 2025, the facility had taken the following actions to correct the noncompliance:Reviewed the deficiency in a QAPI meeting on August 14, 2025. Corrective actions put in place. External Nurse Consultant will review all grievances for any items reported missing and potentially reportable events weekly.In Services were provided on August 14, 2025 and August 18, 2025Monitoring tool put in place for residents funds and belongings