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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145222 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/19/2025 |
| NAME OF PROVIDER OR SUPPLIER LA Bella of Woodstock | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Based on interview and record review, the facility failed to ensure a resident had privacy during personal activities of daily living for 1 of 4 residents (R2) reviewed for resident rights in the sample of 4. The findings include: On 12/19/25 at 8:44 AM, R2 said about a week and a half ago she was getting ready to get up and V3, Maintenance Director, told V6 and V7, Housekeeping, to do a deep cleaning of her room. R2 said the three of them all said she was getting up, but V3 told them to do it anyways. R2 said they closed the curtains while the CNA (certified nursing assistant), V8, was getting her ready (cleaned and dressed), but she still felt uncomfortable. R2 said V6 said R2 is getting up and asked if they could wait until she was done, but V3 said to do it anyway. R2 said she contacted the Ombudsman and asked him to file a formal complaint. On 12/19/25 at 9:58 AM, V6 said they clean residents' rooms when residents are in there, but they absolutely do not clean while residents are getting personal cares. V6 said about two weeks ago, V3 told her to clean a resident room. V6 said she was training V7 and they were about to clean R2's room. The CNA was getting R2 up and ready for the day. V6 said V3 came down the hall and told them to get started on the deep clean of R2's room. V6 said she prefers to do it later because the CNA was getting R2 ready. V6 said V3 told her he had other places he would like to put V7, so he wanted them to get in there and get the deep cleaning done. V6 said V8 looked at them and closed all the (privacy) curtains in the room. V6 said she didn't feel like it was right, but V3 was forceful about getting the room cleaned then and there, so they proceeded to clean the room even though R2 was getting up for the day. On 12/19/25 at 10:16 AM, V7 said on her first day working in the facility, she, V6, and V3 were talking in the hallway. V7 said she was told to go do a deep clean in a resident room. V7 said she and V6 said they should wait because the resident was being changed. V7 said she was learning and just doing what she was told. V7 said they ended up going into the room and cleaning it while a resident was being changed which they usually don't do while personal cares are going on. V7 said she thinks it would be awkward for the resident because it's disrupting their privacy during a personal moment. V7 said the curtains were all closed, and they proceeded to clean the room. V7 said afterwards she and V6 talked about how they felt it was inappropriate. On 12/19/25 at 10:27 AM, V3 said it is not OK to clean the rooms while residents are getting up for the day. V3 said it would be easier for the housekeeper to give them peace and they could come back in a few minutes. V3 said he tries to respect the residents' rights. On 12/19/25 at 11:04 AM, V8 said she remembers getting R2 up after lunch. She told housekeeping she was getting R2 up. R2 said she told them to wait until she gets up, but the housekeepers said they were told by V3 to do it now. V8 said R2 was very upset about it, but she closed the curtains and proceeded to do her incontinence care, dressing, and transfer all the while housekeeping was cleaning the rest of the room. V8 said the housekeepers don't usually do that; she doesn't know why they couldn't wait. V8 said R2 was upset because she was very uncomfortable. V8 said housekeeping usually would step out and wait for her to finish with her cares. On 12/19/25 at 2:24 PM, V2, Director of Nursing (DON), said housekeeping should only come in and clean if the resident says it is OK. The Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities booklet (Revised 11/18) shows the facility must treat residents with dignity and respect and must care for them in a manner that promotes their quality of life and the facility must make arrangements to meet residents' needs and choices.</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff wore a beard guard/net while handling/serving food. This has the potential to affect all 73 residents in the facility. The findings include: The facility's Facility Data Sheet dated 12/19/25 shows 73 residents reside in the facility. On 12/19/25 as the lunch meal was being served/plated in the dining room at 12:08 PM, V15, Cook, was observed to have a beard and was not wearing a beard guard as he plated the residents' meals. On 12/19/25 at 12:30 PM, V4, Dietary Manager, stated a beard guard is required if the (facial) hair is more than an inch long. The facility's Dietary Policies and Procedures Dress Code Policy (not dated) shows beard nets should be used for employees with facial hair.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff performed hand hygiene after touching their face/nose and handling resident food for 1 of 4 residents (R4) reviewed for infection control in the sample of 4. The findings include: On 12/19/25 at 12:22 PM, V11, Certified Nursing Assistant (CNA), was sitting in the dining room feeding R4. V11 had her left hand over her mouth, resting her head on her left hand as she was feeding R4. V11 then rubbed her hands together and ran them over her nose. R4 asked for more bread and V11 went to the serving counter and got more garlic bread and brought it to R4. V11 did not wash her hands or perform hand hygiene before delivering the bread to R4. On 12/29/25 at 12:44 PM, V4, Dietary Manager, stated staff should not touch their face/nose and deliver food to the resident without washing or sanitizing their hands first; it's not sanitary. The facility's Hand Washing Policy (not dated) shows staff should wash their hands before handling food. Staff should wash hands to remove contamination after touching bare human body parts. Hand sanitizer does not replace handwashing.</p> |